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AN INTERDISCIPLINARY JOURNAL FOR THE PROFESSIONS SERVING CHILDREN

White House Conference Followup

A Program for Better Parenting

Security for the Retarded

Services to Children in Their Homes

AN INTERDISCIPLINARY JOURNAL FOR THE PROFESSIONS SERVING CHILDREN

children

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A NEW SENSATION accompanies the learning process for this young finger painter enrolled in a parent-cooperative nursery. Such cooperatives may not only bring the benefits of a nursery school to families with modest incomes, but, for the parents—who take turns helping to teach—may enhance the quality of parenting. Parent-cooperative nurseries are a part of Baltimore's parent education program, described on page 9.

been created at the request of the Governor. Other State committees work with the localities through established State and regional health and welfare organizations.

In an article in the March–April 1960 issue of CHILDREN, summarizing the pre-Conference State reports, Betty Barton and Katharine D. Pringle stated:

> They do not come up with startlingly new knowledge or recommendations—in most instances what they recommend has been heard before from professional and technical groups dealing with health problems, adoptions, court programs for juveniles, dependency, and neglect, and from previous White House conferences. They reflect, however, review of the total environment or any particular group of children.[4]

As might be expected, post-White House Conference activity has been characterized by a narrowing of the focus to a concentration on those comparatively few areas which to the States and communities involved seem to present the greatest need and at the same time the greatest possibility of solution within a reasonable time. However, in many instances these choices have been made without losing sight of the total picture and with full awareness of the need to progress, as time permits, from the present defined activities to broader concerns. Thus, many of the programs which have developed as a result of the Conference reflect the determination of groups of people to translate words into immediate action. For example:

• The Wilson County Youth Commission in Lebanon, Tenn., has tackled the problem of providing vocational training for school dropouts by hiring the skilled teachers necessary to help 35 high school boys learn the construction trades by building a house. When completed, the house will be sold at auction and the proceeds will be used to finance similar projects in the future.

• Beaver County, in Pennsylvania, has already achieved most of the recommendations included in its pre-Conference report: the appointment of a citizens' advisory committee to the juvenile court; the appointment of a probation staff and juvenile police officers, and the establishment of an 8-week training program for them; the employment of a qualified executive for the local health and welfare council; and the establishment of a mental health youth corps to recruit young people into the mental health and social work careers.

• The Maine Committee for Children and Youth, after making a study of personnel in State agencies dealing with children, is working to realize the following recommendations: employment of a qualified full-time person within the department of personnel with authority and funds to carry out a coordinated recruitment program; expansion of summer job training opportunities to introduce more college students to the possibility of careers in services for children; development of undergraduate social welfare programs with field placement opportunities; exploration of the possibility of developing professional education within the State; additional funds and personnel for State staff development programs.

• In Puerto Rico the White House Conference Committee of Adjuntos, a small mountain town, has secured free dental service for school children. It has also arranged for intelligence tests and ophthalmological examinations for selected children. With the help of the police and the local athletic league, the committee has succeeded in having sidewalks built in one of the poorest sections of town.

• In Floydada, Tex., a rancher's wife who was a delegate to the Conference organized home demonstration classes for young Latin-American mothers in sewing, home nursing, food preservation, money management, home furnishing, and crafts. Classes are held in a church; materials are donated by local merchants; and the teachers are ranch women who were themselves taught in home demonstration clubs.

Throughout the States thousands of talks have been given by Conference delegates to tell PTA's, civic and service clubs, church groups, and others the story of the White House Conference and what it can mean in their communities if citizens get behind local efforts to achieve their State's recommendations. In addition, a number of State follow-up committees are sponsoring TV and radio programs and otherwise disseminating information focused on the needs of children and youth, as well as on the services available for them.

Many State committees on children and youth spent the first post-Conference years on efforts to secure the State legislation needed for realizing their chosen objectives. In some States the committees presented formal legislative programs to their legislatures, while in others they served as clearinghouses for information on pending legislation affecting children. Some lobbied directly while others stimulated citizen support of their programs by cooperating with established social action groups.

Although no score sheet is available on the actual number of bills passed or defeated which had the backing of State committees on children and youth, evidence indicates that considerable success has been achieved.

However, some committees have expressed confidence that even where success was not achieved, the process of community education has been effective enough to bring the bills further along in the legislation process.

Methods of Followup

After the Washington meeting, many States convened Little White House Conferences in which delegates and other interested young people and adults selected priorities from a long list of Conference recommendations. Subcommittees were appointed, assignments made, and plans for action developed on local, county, or State levels as seemed most appropriate.

For example, in Oregon each county delegation to a statewide followup conference was asked to submit two recommendations, one relating to specific action it would like to see taken by the 1961 legislature and the other focused on "areas in which problems have been identified but about which we do not have sufficient information to document accurately the need for corrective measures." Out of a 3-day planning meeting came specific recommendations for legislative action which would strengthen local health departments and child guidance centers, establish a citizen recreational advisory board, establish and develop area projects for family counseling, establish a new curriculum with emphasis on political and social philosophies in public schools, and set up a legislative interim study of youth employment. A followup report after the end of the 1961 legislative session tallies the results:

> We lost our measure for a Children's Code. . . . The measure to give legal status to local health departments squeaked through. . . . We secured a measure that gives State assistance to local areas for establishment of diagnostic and treatment centers for mentally and emotionally handicapped children. . . . We secured the budget for putting the graduate school of social work on the road. . . . There is to be an interim committee to study divorce and family breakdown and we hope that this committee includes a look at "family courts". . . . We failed to get our interim committee to study youth employment but we did do a fair educational job on this problem.

As a result, the Oregon committee rated its record as 50–50, with a big plus on the educational and public understanding side.

Other followup achievements in Oregon include a program of family life education, focused on parents of preschool children, now underway in one community; and a study by the Portland Community Council to determine needs in day care. In this study, interviews are being carried out with working mothers in two areas of the city and intake records of institutions caring for preschool children are being examined to determine whether the parents of the children would have placed their children in day-care facilities had they been available.

In New Jersey, four regional conferences were held on specific aspects of community planning for children and youth, and a 2-day symposium was held on residential facilities for children.

The New Jersey Committee on Children and Youth has appointed six task forces with the following concerns: family life education; psychiatric services for children and youth; community health services; educational opportunities for youth; cultural enrichment of community life; protective, correctional, and rehabilitative services to youth. Each task force is charged with responsibility for becoming knowledgeable about the background and current activities, trends, and needs in its province; developing specific programs related to its subject matter; following through on necessary action; and reporting in a statewide conference in 1965.

In Hawaii, 1,100 delegates from 371 agencies and organizations participated in a followup conference sponsored by the Hawaii Commission on Children and Youth. The Commission plans continuing evaluation of progress toward reaching the goals set at this conference and advisory assistance to agencies involved in carrying them out. These goals call for specific attention to: children and youth in low-income housing projects, detention facilities, services and facilities for the treatment and care of emotionally disturbed children, playground needs, protective and legal services to children, illegitimacy,

Key figures at a rally of the Oklahoma Youth Advisory Board, were (left to right) the Board president, the State's Lieutenant-Governor, a speaker, and a Board member.

illegal sale of liquor to minors, family life and the role of the family in citizenship training. County committees on children and youth have also held conferences and are working toward these objectives.

Youth Participation

Although youth participation in followup activity was one of the strongest emphases of the White House Conference, only 12 States actually specify that young people must be included in their followup organizational structures. However, 43 State committees report having young people as active participants in some phase of their programs. How far this is from token participation varies with the State.

However, while youth councils—councils composed entirely of young people—existed in a few States prior to the 1960 White House Conference,[5] others have been formed since the Conference. For instance, in St. Croix and St. Thomas, V. I., shortly after the White House Conference, the Governor proclaimed a youth week and named committees of young people to be responsible for sports, entertainment, and publicity.

Most of the youth councils have held local, regional, or statewide meetings with programs designed primarily by and for young people, adults participating only as consultants. For example:

• In the spring of 1961, the Rhode Island youth council, in cooperation with the Rhode Island Council of Community Services, held a 2-day conference attended by over 200 young people who took part in seminars on intergroup relations, teenage marriage and divorce, youth's values, juvenile delinquency, and conformity among young people. The program committee responsible for planning the conference asked the young people to frame a question representing their deepest concern, and often received the query, "Where are we going?" All of the discussions were carried on in that perspective.

• The Oklahoma Youth Advisory Board held a rally last fall, under the sponsorship of the Governor's Committee on Children and Youth, which drew an attendance of about 800 young people from high schools around the State. With the theme of the conference, "Challenges That Face Today's Youth," the conferees focused on moral and spiritual values; "rededicated Americanism;" acceptance of responsibility in home, family, and community; and physical fitness.

• In Pennsylvania, students of 18 high schools in a tri-county area surrounding the State capital have held discussion groups on four topics: youth evaluates its education; youth in its family relationships; the role of religion in youth development; and youth and standards of conduct. The results of these discussions were brought together by 238 students elected to attend an all-day Capital Area Forum.

• California's youth council has spent 6 months planning a conference in which young people from all parts of the State will concern themselves with methods for developing community service projects.

• The Minnesota Governor's Advisory Council on Children and Youth has surveyed youth in the State through high school student councils, and determined the subject content for regional conferences to be held in 1962. The subjects to be discussed will focus on the general areas of values and standards as they relate to youth. In 1961 the council conducted a Conference on Traffic Safety and Driver Education.

• In Kansas, seven little White House Conferences were held for high school youth in December 1960, under the direction of the Maternal and Child Health Division of the Kansas State Board of Health, on the campuses of Kansas universities and colleges. More than 800 young people and 160 adults took part in discussions on careers in public health and social work, preparation for marriage and parenthood, health problems, nutrition, emotional problems, and driver education.

Youth Employment

The related problems of stimulating job opportunities for youth and of discouraging young people from leaving high school or vocational school before they have finished are occupying the attention of State committees on children and youth and youth councils from coast to coast.

The National Committee for Children and Youth, the national coordinating body created for Conference followup purposes,[6] held a Conference on Unemployed Out-of-School Youth in Urban Areas in Washington in May 1961, where representatives of government, industry, organized labor, the schools, and the various professions serving children and youth met to discuss these problems. [See "Unemployed Youth," CHILDREN, July–August 1961, page 151.] State and local meetings with a similar focus have also been held. For example, the Kansas Council on Children and Youth at its June 1961 meeting formulated an action program for better meeting the educational and employment problems of youth. And in Portland, Oreg., the Metropolitan

Youth Commission held a workshop in March 1961 on the subject, "Dropouts—A Dilemma."

Many of the studies underway in various parts of the country on the causes of school-leaving are under the joint auspices of the State committee on children and youth and the State or local board of education. For example, in Indiana the Governor's Youth Council is cosponsoring a study with the Secondary Principals' Association involving a questionnaire to teachers regarding potential dropouts from school and a followup interview with the young people who do leave.

In several States and localities, the committees on children and youth are cooperating with the State employment services in programs of counseling, testing, and placement services for school dropouts.

In Santa Cruz, Calif., for example, a committee on youth employment has been formed to work with the State employment service in getting satisfactory work experience for teenagers. At the committee's request, the local Business and Professional Women's Club undertook a study focused on the elements in job experiences which make for satisfactory or unsatisfactory employment, which resulted in recommendations for changes in vocational training, counseling, and placement services.

Altogether 34 State committees are working to achieve improvements in the educational, vocational training and counseling, and job placement opportunities for young people.

In Michigan, the State Youth Commission has presented to the Governor a work and service program based on the proposals prepared by the Federal Interdepartmental Committee on Children and Youth for providing every young person between 16 and 21 with an opportunity for creative work for the benefit of the Nation.

Other Concerns

The White House Conference made strong recommendations on the subject of human rights, and many State committees and youth councils explicitly express a concern for *all* children in their statements of purpose. No reports thus far have been received of any of the State committees or youth councils devising action programs specifically focused on the elimination of racial or religious discrimination. However, the criteria of equality of opportunity is implicit in many of the projects these committees have developed.

Nineteen State committees have reported involvement with legislation in behalf of migrants. In Oklahoma the committee backed legislation directing the State Legislative Council to study the problems of migratory labor, and in seven other States committees on children and youth are supporting similar legislation affecting migratory families. In California, New York, and North Dakota, the committees supported bills establishing a minimum wage for agricultural employees. In Pennsylvania, Wisconsin, and Oregon, State White House Conference followup committees have been interested in the passage of bills providing for payment of State funds to local school districts for schools and transportation for migrant children.

Juvenile delinquency, a major pre-Conference concern in many of the States,[3] continues to occupy the attention of many State followup committees. The Wyoming Youth Council, for example, has sponsored a medical legal seminar on juveniles, attended by 30 judges, doctors, lawyers, probation officers, and social workers. Similarly, the Louisiana Youth Commission has stimulated institutes for police officers and juvenile court judges and has successfully worked toward reorganization of the juvenile court.

Many State committees are encouraging the development of special projects on family life education and family counseling. In Georgia, for example, family life education programs are being promoted by the State committee's section on religion; in Illinois the Commission on Children brought together, for a workshop, representatives of several counties interested in establishing family service associations.

Many of the active followup committees are working for improved services to the handicapped. In

MULTIPLE EFFORTS

Who can measure the distance an idea travels or the progeny it produces? And who can trace the ancestry of an idea whose progeny have fashioned a tangible result? Thus it is with the 1960 White House Conference on Children and Youth, which gave impetus to the achievement of goals, many of which had long been glimpsed by persons concerned with the well-being of the young. So many people and organizations have striven toward these goals through various affiliations that the results of their Conference participation cannot be separated out from the results of other efforts, pinned down, and measured. Therefore, the accompanying article does not pretend to be an exhaustive report of even the one phase of post-Conference activity it discusses. It is offered to provide a glimpse of the kinds of efforts that have been made by State and local committees on children and youth in pursuit of Conference objectives. Federal agencies and national organizations are equally active in their followup activities.

Mississippi, for example, the Children's Code Commission was a cosponsor with the Nemours Foundation of a 2-day conference on handicapped children held in Jackson in February 1961. The conference resulted in the formation of an association for handicapped children which is to issue an interpretative bulletin on the needs of handicapped children and a directory of services.

Coordination and Communication

Pre-Conference planning had stimulated local communities to take a hard look at themselves to determine where they measured up and where they fell short in providing services and opportunities for their children and youth. In this they were aided by their State committees which in turn could draw on the consultation services of the White House Conference staff.

When the official White House Conference organization was terminated in the fall of 1960 so that its consultant service was no longer available, the newly established National Committee for Children and Youth and the Children's Bureau, through a temporary special unit for White House Conference followup staffed by specialists in community organization, joined their efforts to make consultation services available to the States which sought help in getting their followup programs underway. Following a national workshop on followup procedures called by the Children's Bureau in October 1960, the Bureau sponsored a series of four regional workshops—in Boston, Chicago, Oklahoma City, and San Francisco—in which the members of State committees came together with representatives of national and Federal agencies from within their regions to exchange experiences and consider ways of strengthening the State committees and advance programs for children and youth.

With the expiration on June 30, 1961, of the funds appropriated by Congress to the Children's Bureau for this purpose, the Bureau's special unit was closed. However, the Bureau continues to provide consultation to the State committees through the services of a special consultant on community organization, and to cooperate with the National Committee for Children and Youth.

While White House Conference followup is not progressing with equal vigor in all the States, clearly the Conference's recommendations have stimulated renewed efforts in the interests of children and young people in villages, townships, cities, counties, and States from coast to coast. This has meant not only increased communication between lay and professional people but also between lay people and other lay people, between professional people and other professional people, and in all possible combinations.

Eyes have been raised from personal or specialized concerns to broad community needs affecting children. For example, the Illinois Chapter of the American Academy of Pediatrics has authorized its committee on implementation of the recommendations of the 1960 White House Conference to poll the entire membership of the Chapter to inquire what civic activities each pediatrician has entered into, and what ones he would be interested to participate in. In this way, the Chapter hopes to make available a pool of interested pediatricians who would be of assistance to local health and welfare agencies for technical advice, service on advisory boards, or other purposes.

Regional representatives of national agencies, public and voluntary, have met together in many instances for the first time, are learning from each other what contribution each is prepared to make to State programs, and are discussing ways of meshing services so that youth may be better served. Their State and local counterparts are making similar discoveries of mutual interest and are considering together how they can fit into the patterns of local needs and plans, as outlined by State committees. Extension services of State universities have proved to be of invaluable help to several State committees.

If such channels of communication can be kept open, it stands to reason not only that the programs now being so energetically undertaken in the States have a better chance of success, but that the program for the 1970 White House Conference will be a realistic part of a continuing process.

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[1] U.S. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau: Children and youth in a changing world; reporting on the Golden Anniversary White House Conference on Children and Youth. *Children,* May–June 1960.

[2] Golden Anniversary White House Conference on Children and Youth: Recommendations; composite report of forum findings. National Committee on Children and Youth, Washington, 1960.

[3] Golden Anniversary White House Conference on Children and Youth: The States report on children and youth. Washington, 1960.

[4] Barton, Betty; Pringle, Katharine D.: Today's children and youth. I. As viewed from the States. *Children,* March–April 1960.

[5] Wright, Sara-Alyce P.: Youth participation in community affairs. *Children,* July–August 1959.

[6] Greenwood, Edward D.: Converting words into action. *Children,* May–June 1960.

Baltimore offers a variety of channels for improving the quality of parenthood through . . .

A COMMUNITY-WIDE PROGRAM OF PARENT EDUCATION

KATHARINE WHITESIDE TAYLOR
Supervisor of Parent Education, Baltimore Public Schools

TWENTY-SEVEN years ago the Baltimore City school system through its Adult Education Division began offering a few courses to help parents in their parenting. Today, Baltimore's program of parent education, greatly expanded, reaches parents in every part of the city. It is carried out by 30 part-time leaders and a full-time supervisor through a variety of methods:

1. Parent education groups for parents of children of various age levels and of children with special problems. These are offered in every area of the city, from the prosperous to the poor. In 1961 there were more than 100 such classes attended by some 2,000 parents.

2. Thirteen parent-cooperative preschools, which have the dual purpose of providing stimulating experiences for preschool children and help to parents in understanding their children's behavior.

3. Weekly television programs which reach an estimated audience of some 40,000.

4. One-day institutes. In 1961 four such institutes reached a total of 500 people.

The total program has two major objectives: (1) to help parents gain an understanding of children's behavior and skill in guiding their children to optimum development; (2) to help them gain the self-confidence needed for using their skills and learning effectively.

In all phases of the program, the principles of human growth and development which underlie children's behavior are emphasized.

The parent education groups fall into two major categories: (1) discussion groups (comprising about three-fourths of all the classes); and (2) preschool observation groups. Usually about 60 of the discussion groups are for parents whose children are in elementary school, and 15 are for parents with children in high school or having special concerns or problems. The discussion groups have 15 to 20 members and the observation groups 10 to 15 members who bring along their own preschool children to form the child groups observed.

Discussion Groups

While the typical discussion group has 30 weekly sessions, some groups decide to meet less frequently. Many parents have attended the same group for several years, some for as many as 5 consecutive years, during which they have displayed marked changes in attitude.

In these groups the discussions grow out of the interests and problems of those enrolled. Even so, at the elementary level during the course of a year they almost invariably include discipline, sibling rivalry, jealousy, anger and fear (in both children and parents), sex education, the child's use of money, family recreation, chores, intrafamily relationships, and parents' need for participation in nonparenting activities. Parents of teenagers nearly always discuss revolt against family standards, allowances, the teenager's need for privacy and freedom, boy-girl relations, and the choice of a vocation. Discussions

With the help of a teacher, these children learn to make paint in one of the parent-cooperative "preschools" in Baltimore, where participating mothers take the preservice training the city requires, then serve as assistant teachers.

are stimulated and enriched by films, skits, role playing, book reports, observation of school programs, and trips.

In the hands of a skillful teacher, such groups help in more ways than learning. There is relaxation as common problems are shared, and as the participants find they may express their feelings freely in a permissive, accepting atmosphere. Equally important, the support from an understanding group seems to help the mothers develop a sense of the significance of the tasks of parenthood, often tragically lacking in young mothers today, yet basic to the maintenance of mental health. The practice of giving each class member an office or committee responsibility, carried out in many of these classes, also helps to increase this sense of significance.

While most of the classes are composed of mothers, a number are composed of both parents, and some of fathers only. The "fathers only" classes were formed for two reasons. First, it is often difficult for both parents to leave at night, since this requires getting a "sitter." Second, some fathers have expressed the feeling that their wives had gotten too far ahead of them in child study and that they therefore needed a class of their own to help them "catch up." Several of these "fathers only" classes have been followed by the formation of a class for both parents.

There have also been groups for grandparents, as well as special groups in preparation for marriage and marriage adjustment aimed at promoting growth-inducing emotional climates both in beginning families and in those farther along.

The program's parent education leaders have also helped parents prepare their children for kindergarten by holding meetings in a number of schools for parents whose children were scheduled to enter kindergarten the following fall, along with the usual arrangements for each mother and child to observe in the kindergarten the child would attend, and to meet the teacher.

Among the offerings for parents with special problems are groups for parents who have no spouse in the home to help in the child-rearing task, groups for parents of physically or mentally handicapped children, and for parents of delinquents.

The groups for "parents without partners" meet with leaders who not only are formally qualified to be parent educators, but also have themselves faced the task of rearing a child alone, thus achieving a deep understanding of the practical and emotional problems of lone parenthood. The parents in these groups have achieved so much support from each other that they have at times continued their group meetings through the summer months when no instructor can be provided.

While the groups for parents of the handicapped have focused on the basic needs of all children, they have also dealt with the special difficulties of the children of each group—blindness, deafness, cerebral palsy, and mental retardation, as well as with the parents' and others' feelings and attitudes toward these children and their handicaps.

The groups for parents of delinquents have been organized at the request of the juvenile court for parents whose children are about to be released from the training schools for juvenile offenders. The focus here is on helping the parents find constructive ways of building healthy relationships with these young people and of providing them with proper guidance. Since attendance at these sessions is optional, not more than a quarter of those parents eligible for them participate. However, the probation officers reports have shown improvement in the attitudes of those who have attended.

Preschool Observation Classes

Parents' preschool observation classes, following plans originating in West Coast cities, were introduced into the Baltimore program 9 years ago, with the inauguration of one such class. There are now

25 of these classes. Their purpose is to reach both mothers and children in the early years of the child's personality formation, when the pace of development is most rapid but when the child is not yet eligible for the school's guidance program. While all observation classes meet weekly for 2½ hours a morning for 30 weeks, new classes may form at any time there is a demand, even during the last 4 weeks of the school year.

Each participating mother in the observation classes brings her preschool child or children (aged 2 to 5) one morning a week to a play group run in connection with them. The parents at first observe the children and later participate in their supervision under a teacher trained in parent education as well as in the education of preschool children. The teacher helps the parents' record their observations. During one hour of the morning the mothers gather in a room adjoining the nursery school to discuss their observations and the principles studied, while the nursery school teacher's assistant supervises the children.

Thus the parents have what may be called "practice teaching" in parenthood, an experience much needed by some parents, but seldom provided. These experiences in seeing and doing are more likely to carry the theories of child care learned in the classes over into the parents' daily child-care practices than those just read or heard about.

After 10 sessions of observation and discussion, mothers are given opportunity to take turns assisting the nursery school teacher in supervising the children. This helps both parents and teachers to evaluate the degree of parent learning.

Each mother keeps a record of her observations of her own child's behavior not only in the group, but also at home. The teacher reads these records each week, writes comments on them, and returns them to the mother. These annotated records, along with the teacher's evaluation of the child's development, serve as a basis of individual parent-teacher conferences regarding both the child's and the mother's progress.

It has been held that no mother can be "objective" about her own child's behavior. While it is true that each mother's feeling about her own child is different than toward other children, and should remain so, the experience of relatively objective recording develops a desirable combination of the objective and subjective, replacing the judgmental with the causal approach to child behavior.

At the end of each year parents make summaries, based on their records, of the progress and major needs of their children and of themselves as parents. Gratifying results are found both among those mothers with a high level of education and those with little educational background. Following is one mother's summary of what happened:

> We wrote down everything the children said and did, then we were given guidance in analyzing and interpreting this "raw" material. Doing that work was an experience I shall never forget. By studying and interpreting the play and words of that small 3-year-old, a new world was revealed to me—the dynamic interworkings of human beings. By studying my child I learned more of myself and my husband and our relationship.

Since most schools are overcrowded and observation groups need nursery facilities for children as well as space for the parents' discussion, housing them has presented a complicated problem. They are held in churches, recreation centers, housing projects, and in cooperative preschool centers when the centers are not in session. This last provision has turned into a happy reciprocal arrangement since observation groups help provide the preliminary training required of the parents who plan to participate in cooperative nurseries.

Cooperative Preschool Centers

Nine years ago, at the completion of a 15-week course on guiding the growth of preschool children, an enterprising group of young mothers formed the Mt. Washington Cooperative Nursery Center, Baltimore's first parent cooperative. Since that time, 12 other parent-cooperative preschools have been opened including one for preschool-age retarded children. While these parent cooperatives are organized and supported entirely by the parents themselves, they are sponsored by the Adult Education Division of the Baltimore Public Schools. The division provides the participating parents with both preliminary training and continuing educational consultation.

A large measure of the success of Baltimore's parent cooperatives is probably attributable to the requirement that each mother attend 12 to 15 training sessions before entering a cooperative, and monthly sessions thereafter. The preservice training is necessary since in these centers the parents serve as assistant teachers under the direction of a trained nursery school teacher. It may be obtained through a course in guiding children's growth offered by the Adult Education Division, through an observation class, or through a summer workshop provided by the Baltimore Council of Parent Cooperatives and

paid for by the parents themselves. In these courses the parents learn methods of child care based on child development principles as well as nursery school procedures. They also learn how to cooperate in a group.

Because the mothers are required to assist in the nursery one day a week, the parent cooperatives do not help solve the problems of day care for the children of working mothers, except in cases where the mother can arrange time off for this purpose. However, they do bring the values of nursery education within the reach of families with modest incomes, since the average cost of participation is around $15 a month. Planned and operated by the parents who use them, they exemplify one of the basic processes of democracy—citizen initiative to meet citizen needs.

In these preschool groups the children not only receive the kind of stimulation of the development of social skills, self-reliance, and creativity all good nursery schools provide, but also—because the presence of their own and their friends' mothers makes for a familiar atmosphere—find a good bridge between the security and informality of home and the world of outsiders soon to be presented by school life.

Equally important for the children is what the parents are apt to gain from this experience. The preliminary and inservice training, the assistance in the group care of children, and the group processes involved in helping to plan the nursery program are all designed to increase the mother's sense of competence in her most important task, the care of her own children. Moreover, the fact that the participating mothers have four mornings free from child care to devote to other pursuits allows them to renew former interests or develop new ones.

Parent cooperatives are even more likely than the traditional parent education discussion groups to help the young mothers overcome a sense of isolation and inadequacy. The participants tend to become a kind of family of families, a result which in a sense may provide a substitute for some of the emotional and practical support available in other times from grandparents and other relatives in large households. The cooperatives may also contribute to the mother's sense of importance. Working for a *group* of children instead of just for one's own in many instances deepens the sense of contributing significantly to society. Wrote one mother:

Until I found this cooperative I felt my life was going down the drain with the dishwater every morning, and my tears flowed down with it. Coming here has virtually saved my life. I feel like a functioning person again. I really enjoy my children now and my husband says I'm more companionable.

The spirit of zestful giving and common purpose usual in parent cooperatives creates a warm emotional climate evident to observers.

Television Programs

For over 10 years the Baltimore school system in cooperation with local television stations has offered parents a weekly television program in child care. For the first 5 years this consisted of a series of skits, each presenting a typical problem of parent-child interaction, enacted by children and parents chosen through the schools and a discussion of the problem by a panel of teachers, parents, and child development specialists. In more recent years the programs consisted of a parent's presentation of a real problem which was then discussed by the school system's parent education supervisor and other specialists. Last year the focus of the programs was changed to concentrate on the problems and interests of parents of infants.

The reason behind this change was the problem of forming class discussion groups for these parents because of their difficulty in getting away from home. Under the present plan, the program presents typical problems of young parents with new babies, which are discussed by a panel composed of the parent education supervisor, one or two parents, and a child development specialist. The response in mail and phone calls indicates that some 40,000 families are reached by each show. Among many others, the topics presented have included: What To Do When Baby Cries; The Thumb Sucker; Feeding the Infant; Traveling With Baby; The Baby Sitter; Father's Share; Toilet Training; Is My Baby Normal; When the Second Baby Comes; The First Trip to the Hospital; When Your Child Will Not Obey; When Your Child Gets Angry; When You Get Angry; When Should Professional Help Be Sought?

Advisory Committees

For some years parent education councils were formed in five areas of the city. Later these were amalgamated into one citywide Parent Education Advisory Committee with parents from the five areas represented and delegates from various interested community agencies and organizations. This group, which served as a clearing house of parent education sources in the city and as a source of many ideas for the school system's program, has recently been

amalgamated with the Maryland Council on Family Relations.

In addition there has been a Principals' Committee on integrating parent education with the school program. This committee of fifteen Baltimore school principals has proved invaluable in suggesting ways the parent education program can collaborate more closely with the schools and in interpreting parent education to the school personnel as well as the school program to the parents. It has also given attention to the possibilities of promoting parent education informally as a by-product of parents' school activities—serving on committees, helping out in playgrounds or lunchrooms, participating in some classroom activities, and conferring with the school principal.

As an outgrowth of the work of this committee a number of schools have developed neighborhood committees to plan parent education programs in their schools. The committee usually consists of the principal, the parent education teacher, and several parents.

Finding and Training Leaders

Discovering leaders competent to carry out these varied offerings has been and continues to be a major problem. Since few colleges prepare specifically for parent education, it has been necessary to seek persons with training and experience in allied fields, providing them with supplementary preservice and and inservice training. The majority of the present staff members are married women with children, who have been teachers, social workers, nurses, or research workers. The majority of those carrying classes for parents of preschool children have had experience in kindergartens and nursery schools. Since all the work is on a part-time basis, it provides professionally trained married women with much needed opportunities for carrying on outside service while rearing a family.

Another large group of leaders has been drawn from the staffs of clinics and social agencies—especially for the groups in marriage and family relations, for fathers only, and for lone parents. They have included psychologists, psychiatrists, a pediatrician, and several social workers. Most of them conduct evening groups.

As needed, orientation courses have stressed human development, functional and dynamic psychology, and family relations. Training is also provided in group processes, discussion leading, role playing, and community resources. This training has been offered through weekly preservice courses including observation of experienced leaders and through monthly meetings and workshops led by professional parent education consultants.

The parent education groups themselves have proven effective recruiting agents, as have have also the parent cooperatives. Teachers and other professional women who leave their positions to marry and have children, enter these groups for help in guiding their families. The more gifted ones are soon recognized by the leaders who give their names to the supervisor for interviews and planning. A number have become outstanding teachers.

Recruitment of Participants

Considerable effort has had to be spent in publicizing these offerings in ways that will insure that all parents who might like to take advantage of them will know about them.

When new programs have been planned, fliers announcing the fact have been distributed through the school principals for the children to take home. In addition, churches and branch libraries have given out leaflets to parents in their neighborhoods, and PTA's and other civic groups have circularized their members. Announcements in citywide and neighborhood newspapers and in the various bulletins and newsletters of schools and other organizations have also been made as have spot announcements on television and radio, especially during the parent education television programs. After many of the TV programs, telephone requests are received for further information about parent education groups or cooperatives.

But, the most effective means of interesting families is the person-to-person contacts of the parents who have found the work worthwhile. In fact, some of these parents have set up promotion committees and have canvassed potentially interested parents in their neighborhoods.

Recruitment has been less of a problem for the groups of parents of preschool children. More calls are received for information about them than about any other parts of the program. At the present writing, finding enough qualified teachers and adequate meeting places for observation projects is the more serious problem.

Another is helping young mothers accept the necessity for adequate training before starting their own parent cooperatives, for careful planning in their search for a competent teacher and suitable quarters, and for meeting the requirements of the health and

fire departments. Most of the groups which have had to have these needs emphasized in their preliminary planning have responded well to guidance in their regard.

A recruitment problem is posed, however, in regard to fathers. Today many students of the family are emphasizing the importance of bringing fathers back into a more central position in their children's lives. While the program has included occasional evening courses for fathers only, several open to both parents, and special "fathers' nights" in connection with the parent cooperatives, more stress needs to be put on efforts to reach fathers on a wider scale in all phases of the program.

As in most parent education programs, all offerings are less readily accepted in areas of lower economic and educational advantages. Because the average family size is likely to be larger in these areas than in more prosperous areas, many of the mothers have small children at home and so cannot leave home even during school hours. Also many mothers of school-age children work outside the home, and so cannot attend day classes. While evening classes are offered in some areas, working mothers are often too tired in the evening to want to attend even when they can afford babysitters. Nevertheless, groups are flourishing in some of the less privileged areas of the city under leaders having special gifts for working with underprivileged families.

This phase of the work has been handicapped at times by the necessity of sustaining the attendance legally required for the provision of a professional teacher through the Adult Education Division. Since underprivileged groups find it harder to maintain a steady average attendance, they more often have to be discontinued because of falling below the needed 10 or 15 persons.

This problem has been further complicated during the last 2 years by the recent introduction of a registration fee of $1 a term. While this small fee has made little difference in the more fortunate neighborhoods and is even reported to have had a stabilizing effect on some groups, in the lower income neighborhoods—where many of the parents are on the public assistance rolls—it also has resulted in the closing of several groups. While a teacher's organization and some interested individuals are providing scholarships for those who feel they cannot pay the fee, some of the parents will not admit their inability to spare this small sum, and they and the classes are both losers.

An urgent need for activities to help in the acculturation of in-migrants from the southern mountains has created a new problem. Many of these people are resistant to "city ways," and they and their children tend to remain outsiders in the community. More intensive attempts are being planned to reach these newcomers, perhaps through lay leaders meeting with small groups in homes in the neighborhood.

Evaluation

While there has been no attempt at formal evaluation of the effects of the parent education program, the fact that many parents have continued to participate in the program during all the years of their children's growth—changing groups with their child's age level—is evidence of value received, so also are such oft-heard remarks as "If only I'd had this with my first child!" or "It has really made our family life over!"

Hundreds of other comments, verbal and written, have been received from those who have participated. The following statements are not unusual in their tone:

• From a mother who attended the course in guiding preschool children's growth:

I started taking this course primarily to obtain the necessary certificate so my sons could get into a parent-cooperative nursery. I was rather skeptical that it would hold much real practical information for me inasmuch as I had had all the psychology, education, and sociology courses available for a 4-year college course in child guidance. But I was ever so wrong! The informality and friendliness of the course was a big change, and I feel that I gained many new insights into child behavior. It was also a deeply gratifying experience just to mix with other young mothers with similar experiences and problems to mine.

• From a mother who attended an observation course:

From observation of my own child and his playmates, I have gained an attitude of patience and understanding heretofore unrealized because I have learned to look for the reason behind the behavior instead of viewing only the behavior. Insight lends patience, and patience lends enjoyment. Enjoyment seems to lend answers.

• From a member of a discussion group:

I'm confident that in my knowledge of the successive growth processes I've found the key to guiding my child. What we expect, what we understand, we can handle. Worry will not be a constant thing now because of this knowledge. And without worry I can love him, enjoy him, and let him grow!

Such statements would seem to attest to the fact that the program in spite of ongoing problems, is helping a number of parents to increase their understanding, skills, and self-confidence as parents.

FOCUSED TREATMENT FOR CHILDREN AT HOME

ELIZABETH G. MEIER
Lecturer, New York School of Social Work

A FEW YEARS AGO, the Children's Bureau and the Child Welfare League of America developed a statement concerning the content of child welfare service[1] which said in part:

> In its specific sense, then, child welfare denotes social work practice in providing social services to children and youth whose parents are unable or need help to carry their child-rearing responsibilities, or whose communities fail to provide the resources and protection that children and their families require. . . . Child welfare services are designed to reinforce, supplement, or substitute for parental functions which parents cannot perform fully; and to improve conditions for children and their families, if necessary, by modifying existing social institutions or organizing new ones.

This definition embraces both services to children in their own homes and provision of foster care as legitimate concerns of child welfare agencies. However, many agencies providing child welfare services do not give enough attention to helping children in their own homes. A recent report concerning the 220,812 children receiving child welfare services from public agencies in 45 States reveals that only a little more than half of these were living in the homes of parents or relatives. Moreover, the proportion of children receiving services who were living with parents and relatives was slightly less than had been found 14 years ago.[2] No comparable figures on a national basis are available in regard to the children served by voluntary agencies, but the proportion served in their own homes may be even smaller.

The word "treatment" in the title of this article refers to the provision of *any type of social service* needed by the child and not exclusively to casework. The word "focus" suggests first that the treatment efforts be directed toward that particular difficulty which interferes with the child's welfare. But also, the word "focus" suggests keeping an eye on the goal. Focus in treatment then requires not only specifically diagnosing what is the trouble, but also treating with specific goals in mind.

Casework, of course, nearly always has the dual goal of helping the individual achieve greater satisfaction for himself and helping him be more socially productive. A statement so generalized, however, provides little help in defining exactly what it is the social caseworker is trying to help individuals and families accomplish. Moreover, it is not always clear, even to the caseworker, what is meant by these large, unspecified goals of social productivity and personal satisfactions.

The only way in which an individual can find satisfactions is in the free use of his physical, intellectual, and emotional energies. Usually these energies can find expression within the established social institutions, the most basic of which, of course, is the family. An adult finds pleasure in the love-making which is part of marriage, in sharing with the sponse the joy of watching baby take his first steps, in figuring whether the family budget can stand the purchase of a new rug, or a watermelon, or a motor boat, or a trip to the mountains. The children learn from within the family gronp the meaning of affection, of quarreling and making up, of sharing and of competing.

Another social institution, the economic system, provides the individual with opportunity to use the strength of his body, his mind, and his creative talents while earning money to buy the necessities and amenities of life. The religious institutions provide him with an opportunity for spiritual expression.

Based on a paper presented at the 1961 forum of the National Conference on Social Welfare.

Formal or informal groups of people provide him with an opportunity for friendly communication with others, recreation, intellectual stimulation, and relaxation.

These and other social institutions provide the individual with opportunities for achieving satisfactions for himself and for contributing to the satisfactions of others.

What does the individual need during his childhood in order to become an adult able to use his vitality freely enough to achieve such satisfactions and to contribute to society? We can list six types of needed experiences:

1. Sufficient food and adequate physical care (including medical care and attention) to enable him to feel comfortable.

2. Stimulation of his senses and his mind so that he may perceive his environment with as little distortion as possible.

3. Help in developing his special talents, in overcoming his special difficulties, and in learning how to earn a living, to stand up for his rights, and to exercise his responsibilities as a citizen.

4. Orientation to and acquaintance with the institutions of society.

5. Association with his peers.

6. The experience of a continuity of relationship with adults who love and care for him—preferably, a man and a woman married to each other, and glad that they are, whose own perception of reality is relatively undistorted, and whose own standards of behavior are accepted by society.

Parents and Community

Modern parents, however capable they may be, are not expected to be a self-sufficient unit in providing their children with all the experiences they need. Consider the many health, educational, and recreational institutions that stand ready to help in this. Indeed, sometimes differentiation between the adequate parent and the neglectful parent is not so much in terms of the parents' own skills and knowledge as in terms of their willingness to use the specialized services available. For example, parents today, unlike parents in an earlier time, must obey compulsory education laws. They have lost the prerogative of deciding for themselves whether they shall send their children to school.

As society comes to regard certain experiences as necessary for children, it tends to provide the institutional structures for these experiences and then to hold parents responsible for making use of them. Unfortunately, however, there is frequently a lag between the time when social needs arise and the provision of the services. Not only parents, but communities too, must be held responsible for providing necessary growth-inducing experiences for children.

Obviously, a considerable share of the community responsibility falls upon the social welfare services. They must include a continuum of child welfare services ranging from those which bring about the least radical changes in a child's experience—such as the improvement of parent-child relationship—to those which bring about the most radical changes, such as placing the child away from his own home.

The capacity for parenthood is not a unitary trait, but is a composite of many kinds of capacities. Focusing attention upon the varieties of experiences which children need forces those serving children to be much more specific in assessing the capacities of individual parents to meet the children's specific needs. Furthermore, it helps the worker to distinguish between those needed experiences which can be supplied through extra-familial sources and those which the child can experience only within the family.

Some Current Tendencies

Certain identifiable tendencies in current practice might be modified if treatment were more sharply focused on providing children with the types of experiences they need. One such tendency is to make the more radical change—placement of the child—without careful appraisal of whether other forms of help to the family might make it possible for them to provide adequately for the child within his own home.

A second tendency, paradoxically, is just the opposite. Family situations identified as hazardous to the welfare of the children are permitted to continue as they are if, after a period of time, the agency is unsuccessful in effecting change. Social agencies sometimes withdraw from a case rather than to carry through a responsibility to remove children from their homes.

Related to this second tendency is a third. Services are sometimes provided in the home with a certain vague apprehension that the situation is not a good one for childen, but without a clear delineation of the specific hazards or deprivations which the

child suffers therein, or a clear perception of the specific qualities of the parents or facets of the family's situation which have a negative impact upon the child.

A fourth tendency has been for social workers to direct most of their concern to just two of the types of experiences which children need—adequate physical care and affectional relationships. This has come about because we have learned a great deal about the impact of deprivations of these two types of experience. For children whose major problems have been physical care or affectional relationships, uncomplicated by other considerations, it might be said that treatment has been focused.

Complicated Problems

I should like now to examine briefly the possibilities of focused treatment in behalf of the many children who live in three types of families—the economically deprived family, the broken family, and the problem-ridden or so-called "hard-to-reach" family. I use the term "so-called" in regard to the "hard-to-reach" since social agencies for a long time did little to put themselves within the reach of many of these problem-ridden families, expecting them to do all the reaching. As Alice Overton and others have found, when agency workers begin to do some of the reaching out themselves, many of these families respond to their help.[3-5]

Obviously, these three groupings of families cannot be regarded as mutually exclusive. Many children undoubtedly live in families to which all three of the designations apply—economically deprived, broken, and problem-ridden.

In the comments which follow, only a few of the effects of these types of family situations upon the children will be identified, and no attempt will be made to provide case analyses and treatment plans. In arriving at a treatment plan for an individual family, an assessment of the specific nature of the interaction between situational pressures and personality structures in that particular family is always necessary.

It has been estimated variously that one-fourth, or one-fifth of the children in this country live in low-income families—depending on the definition of "low income." One such describes a low-income person as "one with an income equivalent to that of a member of a four-person family with total money income of not more than $2,500 in 1957 dollars."[6] Lenore A. Epstein has pointed out that "year after year certain groups of families tend to have lower incomes than the population as a whole" and that "prominent among these groups are nonwhite families generally, families where the head does not work full time throughout the year, and broken families—especially those headed by women."[6]

Effects of Low Income

As we have noted, adequate physical care, including medical care, is one type of experience needed by children. It is surely not necessary to dwell upon the obvious bad effects of low income upon the child's likelihood of receiving adequate food, clothing, and shelter. It may be necessary, however, to call attention to the implications for casework treatment of the deleterious effect of low income upon the amount and quality of medical care which the members of a family are likely to receive. Consider, for example, the cumulative effects of inadequate medical care upon a mother. *No social worker has a right to evaluate the quality of a mother's capacity to care for her children without having a good understanding of the mother's physical condition.* Fatigue, a low-energy level, a chronic low-grade infection—these are but some of the factors which diminish a mother's capacity to respond to the constant needs of her children for physical care, for attention, for affection.

Low income also affects the child's chances of receiving adequate medical attention. Have social agencies used volunteers as often as they might in helping mothers get their children to clinics? When the family income is very low, taking the child to a clinic may mean that the mother has to make a choice between paying two bus fares or buying two loaves of bread.

Social workers sometimes urgently press a mother to take a child to a clinic in spite of the fact that she may have no one with whom to leave her other children and so must go through the exhausting ordeal of taking all of them with her. Perhaps, to the personnel already available on some agency staffs—caseworkers, psychologists, group therapists, homemakers and psychiatric consultants—agencies need to add babysitters who can be available to go into a home while the mother undertakes the clinic trips urged upon her.

While the concept of "togetherness" may be an ideal for suburban families with a car and plenty of space, in the low-income family, living in close quarters, "togetherness" is a grim overdone reality. In the middle-income family the parents can pay a babysitter in order to have an occasional evening

out by themselves. They can send the children to camp for a few weeks in the summer. If illness strikes the mother, they can secure household help. For low-income families, the supply of community supported homemaker services to help out even in grave emergencies is way below the need.

Broken Families

Children in broken families, particularly those of low income, experience additional hazards, arising from the antagonism or disregard of the public.

Much adverse criticism has been leveled against public assistance departments for granting aid to unmarried mothers, and sometimes, even for aiding divorced mothers and those separated from their husbands. The theme of this criticism is the charge that the availability of assistance produces the broken family. Little attention is paid to the fact that a much larger number of children are being cared for in broken families headed by a woman who is not receiving public assistance than are being provided for by public assistance.

The inadequacy of the provisions for day care of children of working mothers has been well substantiated.[7] Some of these working mothers have had to make a choice between using all of their meagre earnings for food, clothing, and shelter and other necessities, or deflecting some of it into payment for the care of the children while they work. The community cannot have it both ways. It cannot complain about the cost of adequate public assistance to mothers in behalf of their children and at the same time be critical of mothers for working or for not making adequate provision for the care of their children while they work. Many working mothers are handicapped in their efforts to provide day care for their children because the day care facilities are too expensive or too inaccessible. And, in some localities of course, such facilities are not available.

In 1959, one out of very 11 families with children was a one-parent family. There may be casework or group work agencies, or churches, or schools which have sponsored groups to which these lone parents might come for counseling in regard to their especially heavy child-rearing responsibilities, but, if there are, they are far from common. However, in some instances, such parents have taken the initiative to form groups for discussion of their common problems.

Marriage counseling, to prevent family breakdown and enhance family living, is one of the oldest forms of casework service and continues to be a primary function of family casework agencies. However, few social agencies have faced the fact that a significant proportion of the adult population consists of persons who, after the dissolution of a marriage, must adjust to a new status, and of persons who find themselves to be stepparents to children of their spouse's former marriage. While the social work literature contains many articles referring to individual clients as widowed, divorced, or separated, and many articles describing conflict within a parent-child-stepparent constellation, there are few, if any, articles calling attention to some of the common stresses and strains inherent in the one-parent family or formulating general principles concerning treatment approaches in such situations.

Problem-Ridden Families

Children living within problem-ridden families may experience all of the hazards so far mentioned plus others which interfere with their receiving adequate physical care. In these families, the mothers often do not have the necessary knowledge and skills to carry on their homemaking responsibilities. Income management, wise food buying, food preparation, dealing with individuals who affect the family living—the landlord, the grocer, the employer—are for them insuperable tasks.

Reports from various experimental projects, including the St. Paul project,[3] have been consistent in stressing the point that casework services to be effective with these families must be directed toward giving the parents practical help in increasing their knowledge and skills so that they may function more effectively on the sites of behavior—in the household as a homemaker and a parent, on the job, and with friends. Impulsive, acting-out behavior, characteristic of many individuals in these families, is more likely to be clinically identifiable as a manifestation of a "character disorder" than as an indication of neurosis. For them, at least in the beginning of treatment, exploration of feelings is not only painful but may be damaging and destructive.

Stimulation of the senses and the mind has been mentioned as an important requirement in child development. In years to come we may learn much more about the effect of sensory experience upon the actual structure of the personality. Already, psychologists have conducted experiments in which some perfectly normal persons, when subjected to conditions depriving them of sensory experiences, developed pathological symptoms. In the absence of sensory stimulation, the subjects had hallucinations

and developed other distorted ideas. Of course, these experiments created conditions of extreme sensory deprivation. However, knowledge of what happens in extreme conditions can sometimes lead to knowledge about the subtle effects of the same phenomena in less extreme form.

In social work practice, we have learned that young children in institutions often do not develop normally. We should recognize that these children are deprived not only of close relationships with adults, but often also of normal opportunities for learning through their senses. We know too that old people rapidly deteriorate if they are placed in a routinized, unstimulating, institutional environment.

An experiment in activity group therapy for children in a family agency has shown that "material things, such as arts and crafts supplies, money for trips, and food, assume a particularly crucial meaning to the severely deprived group members." [8] The use of these items stimulated children to reenact conflicts experienced within family relationships. Brought into the open, therapists could help children deal with their feelings about them. I would suggest that for children in deprived and overburdened families, the value simply of having access to material things should not be underestimated.

Education

We have mentioned the importance of helping the child to develop his special talents and to overcome his special difficulties. This is primarily the responsibility of the schools. Social workers, however, have a responsibility to be knowledgeable about the relationship between the social structure and individual behavior.

It requires little imagination to realize that the children of poverty, of broken families, and of problem-ridden families are among those whose educational opportunities are restricted. Sometimes the restriction comes from the child's own failure to be interested in learning—a lack often associated with failure to receive sensory stimulation in the home and with the attitudes toward education of those around him. But the school difficulties may also be associated with the amount of stimulation provided within the school and the relation of the school's program to what the young person perceives as a realizable goal.

Dr. James B. Conant has pointed to the deplorable conditions of the schools in some of our large-city slums,[9] conditions which result in large numbers of young people dropping out of school as soon as they pass the age of compulsory school attendance and before they have acquired any skills for making a living. Eligible only for routine, dead-end jobs, these young people often have as negative an attitude toward work as they do toward education. For them, vocational training and counseling and education in work attitudes—attained through positive work experience—may be far more effective in reducing behavioral difficulties than any amount of casework therapy. Erik Erikson maintains that "young people must have learned to enjoy a sense of workmanship in order not to need the thrill of destruction." [10]

An agency worker "reaches out" to the family of an overburdened mother, who struggles through the complex of problems created by low income, to meet the constant demands of her children for physical care, attention, and affection.

On the other hand, in some States young people who do have an interest in achieving an education are forced to drop out of school when they pass the age of compulsory school attendance because they are no longer eligible for public assistance under the aid-to-dependent-children program.

Another important factor in the child's development, his orientation to the social institutions, is ordinarily affected by his parents' helping him to understand the meaning and value of the family, the church, the school, the economic system, and the other less formal institutional structures. In many problem-ridden families, the parents have been separated and alienated from the fabric of community life. They must be helped to reestablish themselves

into the community if the child is also not to be so alienated.

In addition to the reaching-out casework approaches which have been found effective, some social agencies today are trying to do this by working with groups of parents who could not be reached in the one-to-one casework relationship, or by using group work in conjunction with casework.[11, 12] While the aim of such activities is to help parents function more effectively as parents, there is reason to believe that they have also helped the parents to develop the tools of communication which can make it easier for them to take their place in community activities.

Another encouraging development is taking place in some public housing projects where group workers have been effective in helping tenants learn to work together in project councils, creating their own rules of expected tenant behavior so that both property and morale can be maintained.

In Summary

The most important ingredient for healthy child development is the experience of affection. This is important, not only for the child's sake, but also for society's, for it is by being loved and cared for that the child develops a conscience. Many of the approaches to parents suggested in this article have the dual intent of freeing their energies so that they can offer more affection to their children, and of helping them develop standards of behavior which are congruent with community standards.

It cannot be assumed that such efforts will always be successful, nor should it be assumed that the child is altogether dependent upon family members for developing standards of behavior. Opportunities for wholesome identifications with other significant adults which serve as a dynamic in the child's behavior are increased as the child is helped to relate himself to some of the social institutions of the community.

In recapitulation, I want to stress the following points:

1. Treatment in behalf of children in their own homes must take into account the varieties of experiences which children need for satisfactory development.

2. Focus in treatment can be achieved only by defining the ways in which the child's situation fails to provide him with the needed experiences.

3. Such an assessment of need will make it possible to use a wider range of treatment techniques and methods, resulting in a lessened tendency to fall back on placement of the child away from home. With the child remaining in his own home the parents can be helped to provide different kinds of experiences for him within and outside the home, and to add extrafamilial persons to the circle of individuals who provide the child with constructive experiences.

4. Treatment in behalf of children involves the provision of many different kinds of experiences through a wide range of persons and is not the monopoly of social workers. The doctor, the nurse, the teacher, minister, the neighbor and employer, the homemaker, the day-care worker, and many other persons as well as the social group worker and the caseworker might, in various combinations, be thought of as the treatment team.

5. That part of the definition of child welfare must be taken seriously which states that it is also a function of child welfare services "to improve conditions for children and their families, if necessary, by modifying existing social institutions or organizing new ones."

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GUARDIANSHIP FOR THE MENTALLY RETARDED

MICHAEL J. BEGAB
Specialist on Social Services to Mentally Retarded Children

HARRIET L. GOLDBERG
Specialist on Child Welfare Legislation

Children's Bureau

PARENTS of normal children generally can look forward to the time when their children will achieve some measure of financial security and social prestige. For many of the retarded, however, in spite of the considerable expansion of educational and training resources that has taken place in recent years, these are still unattainable goals. For those among the retarded who are chronically dependent or semidependent persons, a lifetime plan of guidance, care, and supervision is needed.

The trend toward keeping mentally retarded children in their own homes and integrating them wherever possible into community programs and functions has focused attention on the need for long range planning for them. Many parents have demonstrated remarkable ingenuity and adaptability in meeting the immediate needs of such children. Yet even among the most adequate parents, today's successes are often marred by tomorrow's uncertainties. "Who will look after my retarded child's interests when I am gone or can no longer do so myself?"

The deep concern and anxiety reflected in this oft repeated question is well founded. Parents of retarded children—perhaps better than anyone else—fully realize the self-sacrifice and dedication often entailed in their care. When because of parental effort, the retarded child is happy, content, well-adjusted, and in many ways a contributing member to family and community life, the parents are apt to be reluctant to accept institutional care as the ultimate living arrangement for him. They cannot expect, nor indeed are many willing, to burden other members of the family with the often trying responsibilities of caring for and supervising a retarded adult. They hesitate to seek the assistance of friends for this purpose and fear that strangers may lack understanding of what their children need and how these needs may be fulfilled.

With advances in the medical sciences, the survival rate of damaged infants has been increased and their life expectancy prolonged. More and more, parents are faced with the likelihood that their retarded children will survive them. With machines displacing men from jobs and many families moving from one community to another, life in our society has become more complex. These changes sorely tax the capacities of the handicapped adult for independent functioning and social usefulness.

These developments have brought into sharp focus the need to re-examine existing measures for safeguarding and promoting the welfare of the retarded in case of parental death, disablement, or inadequacy.

Sometimes the need for guardianship stems not only from the incapacities of the retarded person, but from the inadequacies of his parents who are still living. In some cases, parents are unable to meet the physical, emotional, or behavioral problems of their retarded child and are unresponsive to professional efforts to help them. Where these conditions prevail, society, through its established agencies and social institutions, has a responsibility to protect the child's interests and rights and to provide opportunities wherein he may develop to his fullest potentialities. Though the legal rights of children may vary within States, this fundamental value in our culture is an inherent part of our social system as

it is expressed in our customs and in our laws.

Current practice in relation to guardianship and the concepts and philosophy underlying these practices vary greatly. A few States encourage guardianship arrangements under public welfare departments for all retarded persons, whatever the family's status and capacities and the individual's living arrangements. Most widespread, however, is the practice of vesting legal custody and sometimes guardianship responsibilities for the retarded in the superintendents of State institutions, but only for those persons who have been admitted to the institutions—approximately 4 percent of the mentally retarded population. Unfortunately, many families with retarded children at home, who do not plan for institutional placement, do not recognize the need for future guardianship arrangements.

Complexities in the present systems of guardianship are thus formidable obstacles in the long range planning many retarded persons need. Happily, the National Association for Retarded Children and its State and local affiliates are actively exploring different ways of planning for the future of the retarded. It has already launched upon a group insurance program. Among other techniques being considered are arrangements for guardianship.

Forms of Guardianship

The needs of the mentally retarded for protection have long been recognized in the legal systems of many countries and in all the States of the United States, and various methods have been developed to safeguard their welfare and protect their financial and personal interests. Traditionally they have been grouped with the mentally ill and with minors as being mentally incompetent to conduct their own affairs or to perform adult functions such as making wills or conducting litigation.

Various forms of guardianship have been utilized in efforts to promote their interests. These are of four kinds: guardians of the person; guardians of the property; general guardians (of person and property); and guardians *ad litem*, appointed solely in connection with court actions.[1]

In the main, there are relatively few instances of considerable property belonging to the mentally retarded just as there are in the population at large. Usually, the need for guardianship exists more in the area of personal concern and interest in their well-being than in relation to property. Therefore, the appointment of general guardians should probably be made more frequently than separate guardians of the person and of the property for the same individuals. A general guardian could well exercise the necessary fiscal care of moderate amounts of property and at the same time evince the degree of personal interest and concern which is so vital to the welfare of the mentally retarded. In any event, the capacities of the mentally retarded person's natural guardians for this role should be considered paramount. Others should not be substituted for natural guardians during the natural guardians' lifetime unless they are unable to fulfill the responsibilities inherent in guardianship.

Parents are recognized as the natural guardians of their minor children and of their mentally retarded children who reach the age of adulthood and have been *adjudged* incompetent. However, the existence of mental defect in an adult, no matter how apparent, does not automatically confer guardianship responsibilities on his parents. Although in many instances, controversial issues regarding the management of the retarded adult or his estate are not apt to arise, it may be a wise precaution for parents to seek an adjudication of their child's incompetence while they are living. In this way arrangements for future guardianship can be expedited and continuous protection of the child assured.

This concept of the need for a continuation of the natural guardianship functions for the adult retarded child is expressed in provisions of revenue laws concerning dependency exemptions, in social security legislation, particularly regarding eligibility of handicapped dependents for social insurance benefits, and in decisions regarding medical and other forms of care.

Individual Need

Mentally retarded persons—by definition—lack the intelligence and social competency to manage their own affairs with ordinary prudence and judgment. Within this broad definition, however, the range of incapacity is great. A fairly large proportion of the mentally retarded are only identifiable as such and actually function on a defective level only during their school-age years when the expectations and demands of a normal life exceed their abilities. At the age of majority, many of them become self-supporting, and need guidance and supervision only when confronted with situations of serious social stress. For these persons, guardianship may not be necessary.

However, the more severely handicapped or the

less socially adequate, lacking the capacity to act for themselves, need someone who can act in their behalf. Whatever their chronological age, they cannot be expected to behave responsibly in certain situations, to negotiate contracts, or to be liable for their misdeeds—especially in instances where they lack the intelligence to distinguish right from wrong. Even as adults they need social and legal protection against exploitation and also personal guidance toward social adjustment and training.

Retarded persons whose intellectual deficits stem primarily from social and cultural factors often differ markedly from persons who are retarded from other causes in many respects and have a greater capacity for self-direction and self-maintenance as adults. Hence the need for guardianship provisions in these cases is not always apparent. The need should be determined by careful interdisciplinary evaluation and subjected to periodic review, not only of the retarded person's capacity for self-reliance but of the environmental circumstances which may have dictated the need for guardianship in the first place.

Functions and Responsibilities

Much confusion exists in the public mind regarding the functions and responsibilities of legal guardians and how they differ from those of parents. For this reason, some parents hesitate to plan for such arrangements, and at times persons who could be potential guardians are somewhat reluctant to act in this capacity.

In many respects, guardianship and parenthood carry similar responsibilities.[1] Like the parent, the guardian becomes responsible for the care, custody, and control of the child. He is entrusted with authority to make important decisions regarding the well-being of his ward that may affect the individual's whole life. These decisions may involve medical care, employment, consent to marriage, and entry into the armed forces—all of which may be considerations for many of the retarded and problems about which they cannot be expected to exercise sound judgment.

Judicially appointed guardians, on the other hand, are subject to certain limitations to which parents are not subject. These stem from various legal aspects of guardianship. Guardianship—where minority is the basis for appointment—automatically terminates when the child attains his majority. This does not apply in cases based upon mental incompetency. In any case, while the guardianship is in force, the relationship is subject to continuing supervision and review by the court. The wide discretionary powers of the guardian are, in contrast to those of parents, exercised under court direction—at least in theory.

Aids in Planning

Planning for care, education, and treatment, or regulating behavior of the mentally retarded is often complicated by lack of resources and facilities, negative social attitudes, or limited opportunities. In many other instances, the most suitable plan for a retarded ward cannot be carried out because of very limited or totally unavailable financial assets. The guardian has no duty to support and educate the ward except from the ward's own estate, nor does he have any right to the ward's earnings and services.

Guardians cannot always be expected to have the special knowledge to handle effectively the sometimes complex situations involved in the care of a handicapped person. However, they can be helped to discharge their responsibilities toward a retarded ward more effectively when the supervision of the court is supplemented with skilled social services, competent advice, adequate safeguards of the ward's interest, and a plan suited to his special needs.

State laws generally define the conditions relating to the value and kind of property under which a guardian of property must be appointed to hold a fiduciary relationship to the ward. At times, the same person is appointed to act as guardian of the person and estate and is thus called a general guardian. Though this is often a highly desirable practice, where the property involved is not extensive, clarification is essential as to the respective powers and duties of each office. The guardian of the property's activities are confined primarily to the "prudent and economical management" of the estate entrusted to him and these activities are subject to court direction and periodic accounting to the court.

As fiscal responsibilities are better understood, especially as social insurance programs are expanded with wider coverage and larger benefits, parents may become more conscious of the various alternatives available to them in long-range planning for their retarded child. Already, as noted earlier, extensive efforts have been undertaken by parents' associations to familiarize their membership with group life insurance plans and other techniques for the future care and support of their retarded offspring.

Guardianship of mentally retarded children and adults then, particularly in the assumption of certain parental functions, is a weighty responsibility. It is

incumbent upon the courts therefore, and upon the parents who may designate their choice of guardians through last will and testament, to use the best judgment in their selections. Equally important, such appointments call for the availability of skilled social services to the court and guardian.

What happens when both parents die and no provision has been made for guardianship? Much will depend on the age and capacities of the retarded person himself. However, even the obviously retarded person who needs someone to protect his interests is not likely to come to court attention unless an action for dependency or institutional commitment or probate of an estate is initiated. These actions do not ensure that a guardian of the person will be appointed. Therefore, when a retarded person is bereft of his parents it is important that relatives, friends, neighbors, or others concerned with his welfare petition the court to appoint a guardian who will have responsibility for him. Where the welfare of the retarded person is in jeopardy, the public welfare agency has a responsibility for initiating the necessary protective measures, of which guardianship may be a crucial component.

Properly used, the guardian-ward relationship can serve to establish an atmosphere of affection, security, and recognition for the retarded person and contribute to his social growth and development.

Institutional Guardians

As already mentioned, in certain sections of the country it has become customary to replace natural guardians of the mentally retarded with institutional superintendents appointed to serve as guardians for those persons who are involuntarily committed by courts to institutions. Even in many instances of voluntary admissions, such guardians are appointed. The rationale behind such appointments, or the appointment of State welfare directors as guardians of noninstitutionalized persons, is that the appointees can make necessary decisions and promote the interests of their wards.

In practice these systems of public guardianship tend to become routine and stereotyped. The individual is easily lost sight of in these large-scale guardianship systems which are apt to become bookkeeping arrangements rather than socially significant efforts to aid the mentally retarded. Where a single guardian is responsible for hundreds or thousands of retarded persons, he cannot be expected to keep abreast of the individual's changing circumstances and needs. Often whatever action is taken is in response to emergencies or situations of stress, rather than to a positive plan for meeting anticipated needs. Furthermore, complicated legal and supervisory problems may arise when the retarded person is transferred from the institution to some other facility or is returned to the community on family or work placement. These are additional arguments for a one-to-one guardianship arrangement.

Moreover, the appointment of guardians, when parents would like to continue exercising their full responsibility and have demonstrated capacity to do so, is often a disservice to the retarded persons and to the parents themselves. In effect, the parents of children with institutional or State guardians are, or can be, precluded from manifesting a substantial interest in the welfare of these children in regard to many areas of life planning—placement in and release from foster care, special medical service, marriage. This exclusion of the parent militates against a strengthening of the natural ties between institutionalized persons and their families. Such an involuntary estrangement can weaken family relationships and impede the ultimate return of the mentally retarded person into family living. Hence the guardianship can result in a prolongation of the very problems the court action sought to alleviate.

Then too, when public guardians are appointed society is lulled into the belief that all the interests of the retarded are being protected, whereas in reality in many cases only a modicum of protection is afforded.

One of the objectives of guardianship for persons in institutional care, whether this be undertaken by a public guardian or a private citizen, is to facilitate their rehabilitation and return to community life. This objective is interfered with when commitment is accompanied by real or presumed loss of the retarded person's civil rights.

Recruitment and Termination

Guardians for the mentally retarded can be recruited by utilizing the specific interests of various groups of people. One of the principal sources might well be organizations of parents of the retarded where there is a common concern and background of meaningful experience in dealing with the mentally retarded. Many of the members might be encouraged to function productively as guardians. Such parents, particularly those who have resolved their personal conflicts about having a retarded child, possess a unique understanding, sympathy, and feeling for the mentally retarded. Consequently, they

could bring to bear a sympathetic interest which could not be duplicated easily by others.

Local bar associations might be another source of recruitment. The legal training and experience of members of the bar would be a valuable asset in a guardian. Moreover, having bar association members act in this capacity should enhance the interest of these organizations in the retarded.

Another recruitment source might be service groups—men's clubs, women's clubs, civic organizations, and the like. Many such groups are already actively engaged in volunteer work with the retarded and in the sponsorship of social and recreational programs.

An essential component in the productive functioning of guardians appointed from such sources would be cooperation between them and social service agencies within the community. By pooling their understanding of the mentally retarded, by joint planning, by interpretation of special problems and needs, they could accomplish much for the welfare not only of the mentally retarded but of the entire community. Local social agencies would seem to have a particular obligation to help recruit such guardians and to give them guidance and stimulus in their efforts.

Sometimes guardians appointed for the mentally retarded continue on long after the need for such guardianship has disappeared, as, for example, when the retarded person has achieved a degree of social competency where he can reasonably manage his own affairs. Thought should be given to arranging for a periodic review of guardianships in relation to individual circumstances and with regard to the manner in which the duties are carried out. As soon as it is shown that a person can function adequately without guardianship, the arrangement should be terminated. Where the responsibilities of guardianship are not being competently discharged, a successor guardian should be appointed. Generally, courts are required to supervise the activities of judicially appointed guardians. However, the extent to which supervision is exercised and the methods employed vary considerably. There is reason to believe that in practice there is more supervision of guardians of property than of guardians of the person. The vital role of the latter warrants greater community effort and concern in promoting the best possible safeguards.

Legislative Suggestions

It is perhaps time for States to review their laws and administrative practices regarding guardianship and other provisions for the mentally retarded. This can be done by the use of statewide citizens' committees charged with specific responsibilities for both study and report to the State legislature. Many statutory provisions need reexamination in the light of modern developments in psychology, social services, medicine, and other fields.

In such reviews special attention should be given to the clarification of judicial and administrative functions in respect to the mentally retarded and to the provision of services and legal protections which will improve the condition of mentally retarded individuals and promote their well-being.

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[1] Weissman, Irving (in association with Laura Stolzenberg, Harry S. Moore, Jr., and Robbie W. Patterson): Guardianship; a way of fulfilling public responsibility for children. Federal Security Agency, Social Security Administration, Children's Bureau. C.B. Pub. No. 330. 1949.

Our ability as a nation to carry our world leadership role may well rest on our ability to resolve with dispatch and through social justice our intergroup relations. Our youth, it seems to me, are our most valuable potential resource in this demand. If we continue to allow their attitudes toward racial, cultural, and religious differences to be those reflected in our unresolved intergroup conflict, we will have reared a new generation of socially and emotionally crippled adults unable to meet the demands of the world of tomorrow.

James R. Dumpson, New York City Commissioner of Welfare, to the 1961 meeting of the American Public Health Association.

EFFECTS OF THE ADOLESCENT CULTURE

ALBERT J. REISS, JR.
Professor of Sociology, Department of Sociology, University of Michigan, Ann Arbor

"THE ADOLESCENT Society," by James S. Coleman,* a sociologist at Johns Hopkins University, is a report of one of the more worthwhile investigations of adolescent behavior published in the past few years. Its basic assumption has become rather commonplace: that adolescents today look to each other rather than to adults for their social rewards; that they share and participate in a youth culture which "maintains only a few threads of connection with adult society." What is different and important about this book is that it delineates several components of the adolescent social system and explores the implications of them for educational theory and practice.

Recognizing that the effects of the adolescent culture are difficult to discover because of its pervasiveness, the author chooses the strategy of discovering these effects by examining variations in adolescent society among high schools. His investigations were made in 10 high schools, varying in size, socioeconomic status of the students' families, sponsorship (public or church), and other respects.

The major components of the adolescent social system selected by the author for investigation were its culture (values, norms, and customs), its status system which grants prestige only to some adolescents and activities, its elites and popular heroes, and its association patterns. The effects of these on adolescent scholarship, on their use of the mass media of communication, and on their self-evaluation were then examined. The results of these investigations are reported separately for boys and girls. Finally, the author considers the sources of adolescent value systems and the implications of system organization for policy and practice in secondary education.

The Values

Turning first to the value climates of high schools, the author considers the academic achievement orientation of adolescents (how important are grades for being in the leading crowd and for being important in school and being looked up to), the prestige status of the child's family as related to membership in the leading crowd, the importance for the status of athletic achievement (for boys), and popularity with boys (for girls). He concludes that the ten schools are more alike than they are different in these values, but that there is enough variation among them to make it possible to investigate the effect of differences in emphasis on scholastic achievement, family background, and athletic achievement or popularity.

The author also identifies the informal elites (the popular heroes and leaders) within each of the schools and then compares their orientations with the orientations of the non-elites. He concludes that elites are only slightly less oriented to parents than are non-elites yet they do not turn for direction to teachers or to close friends. Rather, they turn to the teenage society as a whole with its rituals and activities.

*Coleman, James S. (with the assistance of John W. C. Johnstone and Kurt Jonassohn): The adolescent society; the social life of the teenager and its impact on education. The Free Press of Glencoe, New York, 1961. 368 pp. $6.95.

The criteria for success in the status system are analyzed by comparing boys who are seen by their peers as the best athletes with those who are seen as the best scholars and by comparing girls in terms of the criteria of "beauty" and "brains." Persons who work with adolescent boys will not be surprised to learn from the results that in general, athletic stardom stands above academic achievement as a symbol of success. However, the author finds variation in the extent to which emphasis is placed on these values. While unable definitely to show the source of these differences, he suggests that they lie in the extent to which scholastic achievement has an independent status in the school. In some schools the pure scholar is rewarded, while in others he is rewarded only if he gains recognition in other activities such as athletics.

No less expected is the author's finding that successful girls are more likely to be those who are popular with boys than those who are scholars. Variations among schools in the emphasis given to scholastic achievement or popularity for girls show that the social-class level of the school is important. Brains in a girl is devalued in the schools in middle-class neighborhoods.

The structures of the students' associations are presented and analyzed only in respect to the smaller schools, since the author believed that the kind of consideration permissible in a report of this nature would only lead to gross oversimplification if such an analysis were attempted on the students in a large school. However, his analysis revealed differences between boys and girls as well as among schools in the association structures. Among boys in all schools, he found that athletic achievement plays such an important role in determining clique status dominance that it precludes dominance by a non-school oriented factor, such as the socioeconomic status of parents. Among girls, socioeconomic status of parents and the values and behaviors of teachers and school administrators apparently play a more important role.

Effects on Behavior

The report gives less attention than one might wish to the effects of the adolescent status system on adolescent behavior, examining these effects only in respect to scholastic achievement, exposure to mass media, and self-evaluations. The analysis shows that when the adolescent social system fails to give an adolescent status and to allow him a positive self-evaluation, he often escapes from negative self-evaluation through submersion in the mass media. It also shows that only in achieving status in those systems which highly reward achievement in an activity (such as dating, friendship, or athletics) can the adolescent "feel good" about himself and not want to be someone different. The author concludes that since only a narrow range of activities brings social rewards within the adolescent social system, only a small percentage of all students are given a chance to "feel good" about themselves.

One example of the effects of the status system on attitudes toward scholastic achievement is the finding that a smaller proportion of the boys chosen by their peers as best students wanted to be remembered as brilliant students than of the boys chosen as the best athletes who wanted to be remembered as athletic stars. However, the best students among the boys were more likely to want to see themselves as scholars than were best students among the girls.

In looking for the sources of adolescent value systems, the author focuses mainly on the effects of the structure of adolescent activities in the status system of the school. He concludes that the school forces the scholar to choose between being selfish by studying hard and being unselfish by pursuing goals which bring glory to the school, principally through athletics. The study testifies to the fact that this is a hard choice.

Implications for Practice

A great merit of this book is the willingness of the sociologist Coleman to struggle with the implications of his findings for school policies and practices. He is not content simply to describe and analyze. As he states in his preface, he has had, since his own high-school days, a deep concern with the question of how to make possible the better functioning of schools in relation to their explicitly stated goals and how to discover ways in which learning may be more profitable during adolescence and adolescence a more satisfying period. It is to these questions that he turns in a final chapter.

Reading this last chapter should be rewarding to most practitioners since it contains few of the usual platitudes urging that something be done without saying what. In it, for example, the author maintains that any attempt to do away with competition as a motivating device in schools would probably fail since it would be based on several important misconceptions about learning and competition. Competition, he points out, is fundamentally a contest for respect and recognition from those around one.

Rather than trying to do away with competition, he suggests that the schools strengthen their alternative competitive models. One approach he suggests is to develop intramural and intrascholastic competition in scholastic matters for the impersonal competition for grades which now characterizes schools. These might include scholastic games, science fairs, "math" tournaments, music contests, and the like. While the reader may disagree with some of Coleman's suggestions for policy or practice, he should most certainly be left with a feeling that their incorporation into the study report makes possible a more intelligent formulation of policy in secondary education.

If the reader is left with some disappointments after finishing this book, these will probably be due to omissions rather than to errors committed. However, he will probably agree with this reviewer that the author is a sophisticated sociologist who is as aware of what he might have done and what he would like to have done as he is of what he has done.

Some readers may wish, for example, that the author had studied a few public schools in the Great Metropolis. Others will be disappointed that there is little material on the school within the community context, or of the adolescent society embedded in the matrix of the school itself in relation to the goals and practices of teachers and administrators. Still others may feel that the bifurcation of the investigation and analysis in relation to boys and to girls leaves one with an incomplete understanding of the adolescent society of boys *and* girls. Finally, others will feel that the observed differences among schools are in many instances so small that the case made is hardly demonstrated.

This is, then, not only an incomplete analysis of the adolescent social system, but one that fails to investigate how this system is embedded in the larger matrix of the school and of the school in that of society. But, how much can one expect!

This study relies almost entirely upon survey interview and questionnaire techniques to gather the data used in testing its hypotheses. Among the types of information obtained from students were sociometric choice-rejection patterns, their value preferences, self-evaluations, and attitudes. Some information also was gathered from school records and published sources. These data are systematically brought to bear on the main hypotheses of the study. However, the absence of any clear-cut criteria for determining the "statistical significance" of findings or the contribution of factors in explaining behavior will trouble some investigators. Others will be troubled by the fact that techniques of social observation were not employed in gathering data on the youth culture or the behavior of adolescents.

In the opinion of this reviewer, the survey techniques are judiciously and capably handled in this investigation, and reveal that much can be learned about youth culture and behavior through the use of such techniques. Nevertheless the study would have been enhanced if other techniques had also been used in gathering information and if other facets of the organizational system in which youth culture is enmeshed had been investigated.

To be sure, growing up has never—in the recorded history of man—been an easy process. But in this age of modern science, of anxiety and insecurity, of automation and technological change, the difficulties and the problems of growing up have assumed unprecedented dimensions. Our adult world presents youth with impossible expectations and frustrating contradictions. . . . we have demanded of youth that they act like adults, possess an adult sense of responsibility, acquire adult skills and knowledge while denying to them any of the significant rewards and experiences of family, of employment, of citizenship that serve as our own most powerful incentives.

Wilbur J. Cohen, Assistant Secretary, Department of Health, Education, and Welfare, to the White House Regional Conference, Detroit.

BOOK NOTES

EXPLORING THE BASE FOR FAMILY THERAPY; papers from the M. Robert Gomberg Memorial Conference. Edited by Nathan W. Ackerman, Frances L. Beatman, and Sanford N. Sherman. Family Service Association of America, New York. 1961. 159 pp. $4.

The editors introduce this collection of papers, from a 1960 interdisciplinary conference focused on family, with the prediction that any breakthrough in the treatment of behavior disturbances will come from a conceptual fusion of the psychological and the social—a fusion already existing in theories of family therapy in which family processes are regarded as a basis for treatment.

The book's 14 authors write from the vantage points of social work, psychiatry, sociology, psychology, or anthropology. They deal with the family as the keystone of all human institutions: the concept of family in casework theory; trends toward preventive practice in family service; intrafamilial alignments and splits in exploratory family theories; biosocial integration in the families of schizophrenics; techniques of family psychotherapy; and psychiatric developments in family therapy.

Recurrent themes among the papers call for a linking of forces between family social work and the social and behavioral sciences; and for a heavier accent, in the development of theory of family processes, on health instead of pathology. The editors are with the Jewish Family Service of New York.

THE PSYCHOLOGY OF HUMAN GROWTH AND DEVELOPMENT. Warren R. Baller and Don C. Charles. Holt, Rinehart, and Winston, New York. 1961. 432 pp. $5.50.

Throughout its 15 chapters, the authors of this text for prospective school teachers stress the value to the teacher of developing sensitivity to pupils' needs and drives.

The book discusses sources of behavior patterns such as inherited and prenatal influences and the physical and emotional factors affecting personality development, including the roles of the school and of the child's own concept of self.

Included is material designed to help the student teacher to synthesize these theories for use in the classroom—and to "see the individual steadily, and to see him whole."

Authors Baller and Charles are from the University of Nebraska and State University of Iowa, respectively.

PARENTAL ATTITUDES AND CHILD BEHAVIOR. Edited by John C. Glidewell. Charles C Thomas, Springfield, Ill. 1961. 253 pp. $8.50.

Does a mother's growing feeling of impotence in influencing her child cause his psychiatric disturbance, or does her feeling stem from the disturbance? Or is the cycle sparked by the child's unexpected behavior, leaving the mother self-doubting, generating more deviant acts by the child, and so on . . .? Concerned with ways of determining the answer to this and other questions related to parent-child interaction, 20 scientists working in sociology, psychology, and psychiatry took part in a conference on "Research in Parental Attitudes and Child Behavior," in St. Louis during 1960—their deliberations forming the core of this book.

The conference was the second in a series of annual workshop conferences on community mental health research sponsored by the Social Science Institute of the Washington University, St. Louis, as part of a community mental health research training program in which the social sciences are applied to the understanding of mental health phenomena and analysis of the practice of prevention.

The 14 papers are arranged in three parts, the first devoted to reports of research in findings related to maternal attitudes and child behavior, the second, to an edited version of spontaneous comments made at the conference on the current status of research in parental attitudes, and the third, to post-conference papers pointing towards paths of future enquiry. In a final chapter, the editor, the institute's program director, sums up and compares major lines of thought with a liberal sprinkling of his own speculations as to the form and focus of future research.

JUVENILE DELINQUENCY IN AMERICAN SOCIETY. Harry Manuel Shulman. Harper, New York. 1961. 802 pp. $8.

This college text and source book for the professional groups concerned with juvenile delinquency represents an attempt to synthesize points of view developed over the past 40 years of practice in child guidance casework, clinical psychology, correctional administration and criminological research. The author, professor of sociology at the College of the City of New York, uses a basic sociological orientation, describing the social pressures on children in our culture that push them towards deviant conduct.

There are 30 chapters grouped under 8 headings encompassing legal aspects, research, social roots, psychiatric and psychological considerations, and group and individual treatment approaches to control. The author regards society's current strategy of control as ambivalent: on the one hand, punitive, and on the other, demanding a variety of treatment methods—neither approach thus far producing evidence of being effective. He calls for the greater use of social sciences for systematic study of existing legal, practitioner, and community efforts toward prevention and control; and for more prodding into the deeper meaning of worldwide juvenile unrest, which he sees as but one of the manifestations of "the malaise of the spirit of our times."

DYNAMICS OF CHILD DEVELOPMENT. Horace B. English. Holt, Rinehart & Winston, New York. 1961. 461 pp. $5.75.

"Girls," observes the author of this book, "are not only as nice as boys, but, from a psychological point of view, probably more important. For the girls will grow up to be the homemakers of the next generation." The theme of home as nurturing matrix for the child's development is diffused throughout this

textbook for teacher training, which has been written with an eye on the needs of parents as well.

The work is an updated, reorganized version of "Child Psychology," by the same author, who holds the post of professor of educational psychology at Ohio State University.

Two of the 14 chapters are devoted to discipline and authority.

Other chapters deal with emotion, motivation, the psychology of physical development, intellectual achievement, social behavior in childhood, and friendship and love in the development of personality. The author's concluding words develop the idea that the child needs help not only in the experience of receiving love but also in giving it.

NARRATIVE OF A CHILD ANALYSIS: the conduct of the psychoanalysis of children as seen in the treatment of a 10-year-old boy. Melanie Klein. Basic Books. New York. 1961. 496 pp. $10.

The way drawings freely executed by 10-year-old Richard—his mother colored light blue, a red-red father, and a yellow starfish brother—were used as major tools in penetrating the deep layers of this young patient's mind is demonstrated in this book about the play-therapy technique of psychoanalysis developed by the author. Her account of 93 clinical sessions with the boy, and comments on specific techniques applied during each, show how his persecutory anxieties are lessened through analysis relating to internal objects and destructive impulses and through bettering his relationship with his "good object," in this case his mother. Ego reinforcement followed.

Reproductions of 74 drawings, 31 in color, depict, through differences in form, color, and treatment, the changing roles of the stellar figures in Richard's life.

MENTAL RETARDATION; readings and resources. Jerome H. Rothstein. Holt, Rinehart, and Winston, New York. 1961. 628 pp. $6.75.

The editor, professor of education at San Francisco State College, has gathered together 56 articles, by almost as many authors in a variety of disciplines, into this source book of information about the mentally retarded and their educational opportunities, for professional workers and parents.

Beginning with a review of the definitions of mental retardation and of past treatment of the retarded, the articles consider various aspects of problems and methods of assessment, diagnosis, and classification; implications for services and preventive efforts; learning theories and school programs; parent counseling; national, State and local programs; teacher qualifications; and research needs.

The editor has reinforced this collection with tables and charts, the latter including a correlation of the book's readings with some of the basic texts on the subject and a comparison of the terminology regarding mental retardation used by various professional groups and organizations. He has also studded the book with other supplementary materials—lists of films, other audiovisual materials, curriculum guides for educable and trainable mentally retarded children, reading lists for parents, and data on public services for these children.

THE HERITAGE OF AMERICAN SOCIAL WORK: readings in its philosophical and institutional development. Ralph E. Pumphrey and Muriel W. Pumphrey. Columbia University Press, New York. 1961. 452 pp. $10.

The lines along which social welfare developed philosophically and practically are mirrored in this documentary history, which counts among its aims assisting social work "out of adolescence into a maturity which builds on, rather than rejects, its history."

Excerpts from selected documents, representing public and private programs and diverse client groups and settings, are grouped into historical eras. The Colonial period—opening with "He Who Would Not Work Must Not Eat," by Captain John Smith—includes selections from the Elizabethan Poor Law and ends with the Revolution. The early national period spans the events up to the Pierce veto in 1854 of a bill to appropriate Federal lands to the States for mental hospitals, which halted a trend toward greater Federal responsibility in social welfare.

The period of national expansion includes reports of the early beginnings of social work conferences, of State boards of public welfare, of the settlement movement, of the charity organization movement, and the social work education. The period of professionalism—beginning with a paper by Mary Richmond and ending with the Supreme Court decision on the constitutionality of the Social Security Act—contains papers and documents showing social workers' efforts up to and through the Great Depression of the thirties to develop a variety of methods and techniques, while continuing to play leading roles in attacking major social problems.

STUTTERING AND WHAT YOU CAN DO ABOUT IT. Wendell Johnson, University of Minnesota Press, Minneapolis. 1961. 208 pp. $3.95.

Beginning with the author's own experience as a stutterer and his parents' persistent but fruitless search for a cure, this book tells about the author's participation in studies at the Iowa Speech Clinic seeking the defect's origin and requiring considerable self-analysis by the investigator. "What started out as a spirited exercise of curiosity turned into more than a quarter of a century of research," he writes.

Eleven chapters, which are addressed to all associated with stutterers and stuttering, tell the story of this research and of parallel efforts toward prevention and cure of the disorder.

Among the book's main themes—some brought to life through snatches of verbatim interviews—is the irrelevancy to stuttering of right- and left-handedness. The author stresses the fact that, contrary to popular belief, stuttering is learned behavior born of doubt and fear, rather than a disorder of muscle function.

LANGUAGE AND THE DISCOVERY OF REALITY: a developmental psychology of perception. Joseph Church. Random House, New York. 1961. 245 pp. $4.

That the individual's psychological maturity can be measured largely by the way he thinks about reality is a key precept in this work on the acquisition of knowledge, particularly language, and the behavioral changes that accommodate this knowledge. The first section, on the preverbal period of growth, demonstrates that the young infant sees meanings rather than objects: He is oblivious to the sirens of

the firetruck outside, but "may well be in distress if the mother sneezes in the next room."

Then, size, shape, color, and the relationship of objects become more objective and less "projective," observes the author. He suspects that an empathetic-like process underlies all communication and is basic to identification. The child's first use of language is skimpy, but he "almost immediately senses this new tool's power, which at its highest development becomes the power to capture the world in a net of symbols," in fact, to "turn the universe inside out."

Following a series of discussions on subjects ranging from meaning and reference to emotion and motivation, the author advises psychologists to pay more attention to the role of environment in shaping our behavior and not to justify their principles by reference to those of physiology or physics. In his opinion psychology ought to do more research in the distinctly human areas of functioning, instead of concentrating on the "basic" processes.

The author is associate professor of child psychology at Vassar College.

50TH ANNIVERSARY, CHILDREN'S BUREAU

PLANS are underway both inside and outside of the Department of Health, Education, and Welfare for celebration of the 50th anniversary of the Children's Bureau, created by an Act of Congress on April 9, 1912, to provide the Nation with a special arm of government for promoting the health and well-being of its young. The celebrations, beginning with a special issue of CHILDREN for March–April, will focus on children today and in the future and will involve a number of other special publications and at least one major event—an all-day symposium and dinner meeting in Washington on April 9, sponsored by the Citizens Committee for the Golden Anniversary Celebration of the Children's Bureau.

Plans for the Citizens Committee's celebration were spearheaded by an 18-member organizing group of national leaders in the health and welfare fields, including a number from national voluntary agencies, under the chairmanship of Melvin A. Glasser, Dean of University Resources for Brandeis University, and one-time associate chief of the Children's Bureau. In a letter last August apprising the Secretary of Health, Education, and Welfare, Abraham A. Ribicoff, of the fact that a number of individuals associated with health and welfare services wished to organize a celebration of the anniversary, Mr. Glasser noted that the Bureau "has established principle and showed the way for Federal responsibility and leadership in the prevention of child labor and in programs of health and welfare which subsequently have been reflected in activities far beyond the children's field itself."

The Secretary has offered his full cooperation with the plan. Katherine B. Oettinger, Chief of the Children's Bureau is serving as the Department's liaison with the group. Staff services and headquarters have been furnished to the organizing group by the National Association of Social Workers, which is also working with its chapters in recognizing this anniversary.

The theme of the April 9 meetings will be "National Goals for Children." About 1,000 persons whose activities are closely involved with the concerns of the Children's Bureau will be invited to attend. Chairman of the program committee is Mrs. Randolph Guggenheimer of New York.

The full roster of the Citizens Committee has at this writing not yet been completed. Members of the organizing group, besides Mr. Glasser, are: Leona Baumgartner, M.D., commissioner, New York City Department of Health; Bertram Beck, associate executive secretary, National Association of Social Workers; Mrs. Richard J. Bernhard, president, Child Welfare League of America; Robert E. Bondy, director, National Social Welfare Assembly; Loula Dunn, director, American Public Welfare Association; Fedele F. Fauri, dean, University of Michigan School of Social Work; Mrs. Thomas Herlihy, Jr., Wilmington, Del.; Mrs. Clifford N. Jenkins, president, National Congress of Parents and Teachers; Donald E. Long, judge, Domestic Relations Department, Oregon Circuit Court; Norman V. Lourie, executive deputy secretary of welfare, Pennsylvania Department of Welfare; Mrs. H. Edmund Lunken, president, Association of the Junior Leagues of America; Leonard Mayo, director, Association for the Aid of Crippled Children; Margaret Mealey, executive director, National Council of Catholic Women; Mrs. E. Lee Ozbrin, president, General Federation of Women's Clubs; Myron E. Wegman, M.D., dean, University of Michigan School of Public Health; George M. Wheatley, M.D., medical director of health and welfare, Metropolitan Life Insurance Co.; and Whitney M. Young, executive director, National Urban League.

Special Issue of CHILDREN

The special anniversary issue of CHILDREN will be an extra-sized number, devoted to a consideration of the prospects of children in the world today and in the foreseeable future; the relevancy to these of the principles which have shaped our present health and welfare programs for children and young people; what we do and do not know about children generally; and the problems of applying what we do know in their behalf. Among the authors in this issue will be Katherine B. Oettinger; Leona Baumgartner; Leonard Mayo in collaboration with Joseph Reid, director of the Child Welfare League of America; Adelaide Sinclair, deputy director of UNICEF; Edwin Gold, director of obstetrics, Jewish Hospital of Brooklyn; Julius B. Richmond, M.D., professor and chairman of pediatrics, with Bettye Caldwell, research psychologist, State University of New York, Syracuse; and Eli Cohen, director of the National Committee on the Employment of Youth of the National Child Labor Committee.

HERE AND THERE

Inter-American Children's Institute

Meeting in Washington for the first time in its 34-year history, the Directing Council of the Inter-American Children's Institute held its 42d session of the Pan American Union October 16–20, with official representatives of all 21 American Republics in attendance.

Formerly known as the American International Institute for the Protection of Childhood (the present name was adopted in 1957), the Institute serves as a "center of information, study, documentation, consultation, advice, and social action on all problems relating to maternity, childhood, adolescence, and the family, in America."

The Director General, Dr. Víctor Escardó y Anaya, and members of his technical staff reported that the Institute is making strong efforts to deal with certain priority problems affecting children and youth in the Americas, including nutrition, birth registration, delinquency, and care of abandoned children, and that it is developing closer working relationships with the specialized organizations of the United Nations and the Organization of American States, as well as with certain voluntary agencies such as the Unitarian Service Committee which is cooperating with the Institute in attacking the number one problem of child malnutrition. Representatives of several of these organizations, notably UNICEF, the Pan American Health Organization, the Inter-American Commission of Women, and the Unitarian Service Committee were present as observers.

In addition to approving the annual work program and budget for the following year, the Council approved, with amendments, the draft of an agreement under which the Institute would be integrated into the administrative and fiscal machinery of the Organization of American States, while at the same time retaining its complete technical autonomy and maintaining its headquarters in Montevideo, Uruguay. The draft of this agreement, as approved by the Institute's Directing Council, was left with the Secretary General of the OAS to be submitted to that organization's Council. Upon approval by the Council of the OAS, the agreement will go to the Secretary General of the OAS and the Director General of the IACI for their signatures. It will probably not take effect until the beginning of fiscal 1963 unless administrative plans for the changeover can be completed earlier.

The Council also approved the draft of an agreement establishing working relationships between the Inter-American Children's Institute and the International Children's Center, which has its headquarters in Paris. The ICC, an agency of the French Government which annually receives a large grant of funds from UNICEF, has recently conducted programs within the Americas, including seminars for professional workers and short courses for pediatricians. Because of the overlap of interests and activities of the two organizations, an agreement was proposed to consolidate the basis of cooperation established informally a year ago when the Institute and the Center jointly conducted a training seminar on perinatal mortality in Montevideo, with an inter-American faculty and trainees from the various American Republics.

The work program approved by the Council of the Institute for fiscal 1963 provides for continuation of the symposia on child nutrition initiated with the support of the Unitarian Service Committee in 1958. These will begin in January 1962, with two symposia in Argentina cosponsored by the Universities of Mendoza and Santa Fe, and one in Bolivia cosponsored by the Bolivian Pediatric Society.

The Council also approved a recommendation made to the Institute by the Pan American Health Organization that it conduct a training course on nutrition for social workers. Approval was also given to a proposed seminar for high-level administrative personnel of children's programs to draw up standards, guidelines, and recommendations in respect to the protection of children for the use of experts in the American countries who are planning programs of national development related to the Alliance for Progress and the Act of Bogotá, adopted by the OAS in 1960. High priority was voted for a demonstration project of prevention and treatment of juvenile delinquency in Haiti, in connection with which the Haitian Government has made extensive preliminary studies and for which it will provide most of the personnel.

The Institute has been increasingly active in the publications field and has translated into Spanish three Children's Bureau publications: "The Child Who is Mentally Retarded"; "Child-Caring Institutions"; and "Child Welfare as a Field of Social Work Practice." Other of the Institute's publications include compilations of the adoption laws of all American countries and of children's codes.

The Directing Council will meet again in June 1962, in Montevideo, Uruguay.

—Elisabeth Shirley Enochs

Staff Development

Staff development as an administrative function to help solve the interrelated problems of achieving greater competence and greater availability of public welfare personnel was discussed at a 7-day meeting of 68 staff development representatives from State public welfare departments, held in Washington, D.C., September 25–October 3, 1961. The meeting was sponsored jointly by the Children's Bureau and the Bureau of Public Assistance, Department of Health, Education, and Welfare.

The major task of the group was to review and discuss basic training materials that could be used by agencies as standards against which to measure the effectiveness of their programs. The draft material was prepared by a committee of training specialists of the two Bureaus, in response to the expressed need of the States for such standards. The Bureaus are now revising the material according to suggestions made at the meeting, in preparation for a forthcoming publication.

The group gave special attention to the place of staff development in the structure of the agency and its role in policy formation. The members related

the principles of staff development to practice and examined the barriers that prevent the successful implementation of them. Emphasis was placed on: the need for comprehensive and long-term planning; the responsibility for participation by staff development representatives in policy formation affecting staff performance; the need for a clearer definition of the relation of an overall staff development person to other agency staff carrying some staff development functions; and the need for constant assessment of both planning and methods in relation to the achievement of a better quality of service.

The meeting also gave attention to training in relation to emergency welfare services, with techniques suggested for staff training in this regard. A syllabus on such services, which had been prepared for use of the group, was recognized as having application for training in other areas of public welfare.

The agenda also included consideration of appropriate utilization of staff. This involved discussion of a current research project of the Bureau of Public Assistance, the Educational Standards Project, which is an attempt to define the functions appropriate to the job of the caseworker in the aid-to-dependent-children program. The project will also attempt to determine which of these functions require professional knowledge and skills, if they are to be performed acceptably, and which might be carried successfully by nonprofessional personnel. The participants recognized the approach used in this project as one that might be adapted to other social services.

—Bessie Trout

Rehabilitation

A fellowship on postgraduate training for a foreign physician has been established at the Department of Physical Medicine and Rehabilitation, New York University Medical Center, by the World Rehabilitation Fund and the International Union for Child Welfare. Created in honor of the late Mary Dingman, former member of the international staff of the Young Women's Christian Association, the fellowship will provide for at least a year of training. In the selection of the trainee, preference will be given to women physicians who have worked primarily with handicapped children and youth.

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To stimulate voluntary activity throughout the world towards rehabilitation of the disabled, seven awards have been set up by the Reader's Digest Foundation for groups here and abroad who have given distinguished service in this work for their communities during the 2-year period, 1961-62. Ranging from $500 to $2,500, the awards will be presented at the Ninth World Congress of the International Society for Rehabilitation of the Disabled in Copenhagen, Denmark, in June 1963.

A seven-member board of international experts will make the selections, considering first the status of services within the community in 1960, then the degree of voluntary leadership used in assessing needs of and providing services for the handicapped; actions to remove blocks to developing such services; and efforts to develop programs to employ the handicapped and for the education and medical care of crippled children.

A brochure about the awards and ways to apply for them is available from the International Society for Rehabilitation of the Disabled, 701 First Avenue, New York 17.

Child Welfare

A research project aimed at developing a professional training program for child-care counselors is about to be initiated jointly by the Jewish Board of Guardians and Teachers College, Columbia University, with a 2-year grant of $55,000 from the National Institutes of Health, Public Health Service.

With the purpose of increasing the effectiveness of residential institutions and day-care centers, the project will include analysis of the child-care counselor's functions, identification of required responsibilities and skills, and construction of an appropriate curriculum for developing them. It will be guided by a technical advisory committee representative of the sponsoring agencies, the Children's Bureau, the Child Welfare League of America, the New York School of Social Work, and the fields of anthropology, psychology, and nursing.

This committee will be under the chairmanship of Hersehel Alt, executive director of the Jewish Board of Guardians. Also working with the project will be an interdepartmental Teachers College committee.

Director and co-director, respectively, of the project will be Jerome M. Goldsmith, director of the Board's Hawthorne Cedar Knolls School, and Maurice Fouracre of Teachers College.

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Three years' study of the question of family desertion by the public welfare division of the Canadian Welfare Council, based on a review of social work literature and on the files of Canadian public and voluntary agencies, culminated recently in a report on the causes and effects of desertion. The Council has included recommendations to social agencies, courts, and provincial governments for specific objectives and procedures that would reduce the incidence of family breakup, and ameliorate the ill effects on those deserted.

With heavy accent on the importance of distinguishing between the immediate and the underlying causes of desertion and on the value for the community of preventive rather than punitive action, the report advises agencies to coordinate their services with those of other agencies. Financial aid to deserted wives, the Council maintains, should not hinge on the initiation of a suit for nonsupport. Among other areas recommended for further study is the possible effect of social pressure to marry in propelling the young into hasty marriages ending in desertion.

The report is obtainable from the Canadian Welfare Council, 55 Parkdale Ave., Ottawa; price 50 cents (Canadian).

Mental Retardation

Calling for a "comprehensive and coordinated attack" on mental retardation, President Kennedy in mid-October appointed a 24-member panel of physicians, scientists, educators, social workers, lawyers, psychologists, and other specialists to chart the lines of strategy for a national program to prevent and treat mental retardation. Leonard Mayo, director of the Association for the Aid of Crippled Children, was named as chairman; and George Tarjan, superintendent and medical director of the Pacific State Hospital, Pomona, Calif., as vice-chairman.

The President charged the committee with the following responsibilities:

- The exploration of ways to prevent

and ways to cure mental retardation.

- The study of factors relevant to this condition, including biological, psychological, educational, vocational, and socioeconomic aspects.
- The identification of gaps in current mental retardation programs and failures in the coordination of their activities.
- The appraisal of possibilities for greater use of present knowledge about mental retardation.

The panel was directed to review and make recommendations on four specific topics by the end of 1962: (1) personnel needed for developing and applying new knowledge on mental retardation; (2) the major areas of concern offering the most hope, and the means, techniques, and private and governmental structures necessary for encouraging research in these areas: (3) the current programs of treatment, education, and rehabilitation; and (4) the relations between the Federal Government, the States, and private resources in their common efforts to eliminate mental retardation.

WHC Followup

The task of educating children and youth—especially the aspect of vocational training and guidance—ranks first among areas of concern related to the welfare of young people, according to a poll of some 227 national youth-serving organizations, conducted in 1961 and reported recently by the National Committee for Children and Youth. The organizations were polled through a questionnaire asking each to list five problem areas in order of priority.

The resulting picture plus recommendations for Committee action which were also elicited by the questionnaire were expected to furnish guidelines for planning the Committee's future emphasis.

The overall order of priority for the reported spheres of concern were these, after education: the family; values and ideals; delinquency; human rights; citizenship; employment; religion; leadership; leisure activities; the handicapped; mass media; and health education.

The questionnaire was developed on the request and with the collaboration of the Council of National Organizations for Children and Youth, which had conducted a study of such organizations' activities and their areas of concern in January 1961 as a followup of the 1960 White House Conference on Children and Youth.

The report is available on request from the NCCY, 1145 19th Street, NW., Washington 8, D.C.

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A wide spectrum of activities focused on promoting youth employment opportunities—ranging from planning the remodeling of school curricula to fit pupils' likely work prospects in the future, to opening youth employment centers—have been reported by public and voluntary agencies throughout the Nation in followup of the 1961 Conference on Unemployed Out-of-School Youth in Urban Areas. (See CHILDREN, July–August 1961, page 151.) The conference sponsor, the National Committee for Children and Youth, has compiled and indexed responses to questionnaires sent to conferees, in a preliminary report which also sums up the recommendations made by respondents for action by the Committee.

The responses indicated that followup conferences on the subject were held in many of the 15 large cities on which the conference especially focused attention and that plans for specific action were made at these conferences.

The respondents proposed, among other recommendations, that the National Committee for Children and Youth convene conferences on specific occupations, act as information clearinghouse, coordinator, and stimulus for activities promoting youth employment, and interpret to the public, youth's employment needs and the agencies' efforts to meet them. The report is available on request from the NCCY, 1145 19th Street, NW., Washington 8, D.C.

For Health

The progress to date toward development and commercial output of a measles vaccine was reviewed during the first International Conference on Measles Immunization, held November 7 through 9 at the National Institutes of Health, Public Health Service, in Bethesda, Md. Several hundred virologists, physicians, and independent investigators attended the conference, which was jointly sponsored by the University of Colorado, the National Institute of Allergy and Infectious Diseases, and the Institutes' Division of Biologics Standards.

About 80 papers by investigators from 22 countries were presented on subjects ranging from reports of field trials with attenuated live and killed measles virus vaccines, to epidemiological aspects of the disease and the future of measles immunization. Reports on the vaccines indicated that the attenuated live-virus vaccine would provide the most long-lasting immunity to the disease with only one shot, but that it often produces uncomfortable side effects, including a high fever. Effective experiments in reducing these side effects through the simultaneous administration of the blood plasma fraction, gamma globulin, were also reported.

An official of the Institutes announced that a proposed set of requirements for production of a live-virus vaccine had already been circulated among interested scientists, but because of the considerable time and effort needed for drawing up the actual regulations for licensing, he said he could not predict when commercial vaccine output would start.

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A recommendation for audiometric screening at specific lower intensities of loudness than now generally used was among those made in a national conference on identification audiometry, whose proceedings are the basis for a recent monograph.

Published by the American Speech and Hearing Association with support from the Children's Bureau, the monograph includes a report on research in hearing among children conducted at the School of Public Health of the University of Pittsburgh. This research emphasizes that, on the average, children's hearing is more sensitive than would be indicated by the testing levels customarily used as a normal hearing threshold.

The participants of the conference, held in Baltimore in 1960, consisted of research experts as well as directors of programs of identification audiometry. The publication, *Identification Audiometry*, defines this kind of testing to be different from diagnostic audiometry in that it does not consider the degree, kind, or cause of hearing impairment. The contents of the publication span a variety of issues concerned with the validity and reliability of testing procedures and equipment; program development; personnel and management questions; followup of

preschool-age children; and some aspects of industrial and military audiology.

The publication is available from the American Speech and Hearing Association, 101 Connecticut Ave., NW., Washington, D.C., price $1.90, less in quantity.

For Youth

As a result of a recommendation of the 1960 White House Conference on Children and Youth, plans have been drawn up for demonstration projects in which Selective Service registrants who fail medical examinations will be referred, on a voluntary basis, to sources of medical care in their communities. Scheduled to begin in early 1962 at five Armed Forces Examining Stations in Pennsylvania and New York City, the projects will use trained health personnel from State and local health departments to counsel the rejectees before referral.

The plans stem from the work of a subcommittee of the Interdepartmental Committee on Children and Youth, which includes representatives of the Selective Service System, the Public Health Service, the Offices of Education and Vocational Rehabilitation, the Bureau of Employment Security, and the Department of the Army. Appointed to explore the effects of the peacetime draft on youth and on the Nation, as requested by the White House Conference, the subcommittee recommended the use of draft data to bring together youth needing help and the community agencies that can provide it.

According to Selective Service statistics, about 20–25 percent of the persons examined for military service fail to meet medical standards of the Armed Forces.

The plans call for: administration of the projects by the State and local health departments, with aid from the Public Health Service on technical matters and in maintaining liaison with participating Federal agencies; the provision of counseling to rejectees and referral of them for treatment to their private physicians or to proprietary, voluntary, and official health facilities and agencies; and followup by public health departments to determine the extent of rejectees' response to the counseling and referral.

As a by-product, the health departments are expected to derive, from the project's data, yardsticks for measuring their progress toward the achievement of their objectives.

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In mid-November, President Kennedy appointed a Committee on Youth Employment, composed of 23 Federal, State, and local officials and private citizens under the chairmanship of Secretary of Labor Arthur J. Goldberg, to map lines of strategy toward opening up job opportunities for unemployed youths. Dr. James B. Conant, former president of Harvard University, was appointed vice-chairman of the committee.

The action followed recommendations submitted to the President by Secretary Goldberg, charting as spheres of action for the group: the marshalling and coordinating of official and private resources for the attack on youth unemployment; developing public support of youth employment programs; urging creation of State and local counterparts of the Committee; and acting as a clearinghouse for research and information on the subject.

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Progress in modifying the behavior of an adolescent gang occurs in spurts rather than evenly, according to the findings of a research and service project for delinquent and potentially delinquent youth in Syracuse, N.Y., recently reported on by the Huntington Family Centers. In the 3-year project, which ended in October 1960, a diagnostic approach integrating casework and groupwork methods was used in serving these normally hard-to-reach young people.

Four groups of adolescent boys were served, each group having 5 to 11 members. Many boys were from weak or broken homes in the city's "East Side," where there is a high incidence of social disorganization.

Each group was served by a single worker, carrying out a program that included—in addition to play on a farm, organized sports, and social dancing—the serving of food after each meeting and the use of a car as a "floating clubhouse." Limited casework was extended to members of the boys' families.

Among other findings were the following:

• Wide variations among the boys served to indicate that they could not be treated alike.

• Most of the boys were able to understand and alter their behavior.

• These "hard-to-reach" youth in Syracuse differed considerably from the highly structured youth gangs, with definite leadership, purpose, and "turf," that are found in New York City.

The project is described in a report,

SCHOOL DESEGREGATION

In the fall of 1961, 37 school districts in the Southern and "border" States were newly desegregated—25 voluntarily and the others under court order, according to statistics from the Southern Education Reporting Service of Nashville, Tenn. This brings the total of desegregated districts in these States to 897, including 104 desegregated in policy only. The new actions involve 1,120 Negro pupils.

Here is the count:

State	Newly desegregated school districts	Total desegregated school districts (actual and policy only)	Total school districts
Delaware	6	92	92
Florida	4	5	67
Georgia	1	1	198
Kentucky	4	134	211
North Carolina	1	11	173
Tennessee	6	13	154
Texas	7	148	1,485
Virginia	8	19	131

In the other Southern and border States the score is as follows:

State	Desegregated school districts	Total school districts
Alabama	0	114
Arkansas	10	418
District of Columbia	1	1
Louisiana	1	67
Maryland	23	24
Mississippi	0	151
Missouri (estimated)	201	1,692
Oklahoma	195	1,232
South Carolina	0	108
West Virginia	43	55

"Reaching the Hard-To-Reach," by Norman R. Roth, the project's research director, published by the Huntington Family Centers, 512 Almond Street, Syracuse, New York. (Price $1.50, from the Centers.)

Redesign for Welfare

The first moves in a broad plan to remodel Federal participation in public welfare services were announced December 11, by Health, Education, and Welfare Secretary Abraham A. Ribicoff. The Secretary outlined 10 changes which can be achieved through administrative action. All of them were focused on stimulating independence in families receiving public assistance, especially in the program of aid to dependent children. Other changes requiring legislative action are to be proposed to Congress in January.

The announcement came following the release of three reports concerned with the program and operation of the Federal Government's public welfare program: (1) the report of an ad hoc committee of social workers, under the chairmanship of Sanford Solender, executive vice-president of the National Jewish Welfare Board, appointed by the Secretary last spring to study the welfare programs of the Department of Health, Education, and Welfare; (2) recommendations relating to administrative and program actions of the Bureau of Public Assistance and the Children's Bureau, prepared by George K. Wyman, former deputy commissioner of Social Security, under a grant by the Field Foundation; and (3) a report of the Project on Public Services for Families and Children sponsored by the New York School of Social Work, prepared by Elizabeth Wickenden and Winifred Bell.

The first 7 of the 10 changes affect the conditions under which States may receive Federal matching for the assistance programs. They specify that the State:

1. Must set up, in its public assistance agency, a special unit responsible for locating deserting parents of children in the aid-to-dependent-children program.

2. Must fortify procedures for control and prevention of fraud.

3. May allow children on the assistance rolls to retain earnings for future needs such as education, medical services, or preparation for employment, in order to increase their incentives for achieving independence.

4, 5, 6. Must provide intensive casework services—through home visits at least every 3 months, the use of best qualified staff with low caseloads, and coordination with child welfare services—to families with special problems including those with unmarried parents, deserting parents, or hazardous home conditions, in order to safeguard the children.

7. Must submit, by July 1, 1962, a 5-year plan for increasing the training of qualified social workers, including provision for at least one full-time training position by that date.

The remaining three revisions called for:

8. Renaming the Bureau of Public Assistance, the Bureau of Family Services.

9. Setting up within this Bureau, a Division of Welfare Services to be concerned with encouraging the development of more effective family welfare services within the State agencies.

10. Creating the post of assistant commissioner of Social Security to direct the coordination of the aid-to-dependent-children program with the child welfare program of the Children's Bureau.

The Secretary has called for a conference of State Welfare Administrators in Washington in late January to discuss these and other prospective changes.

GUIDES AND REPORTS

EQUIPMENT AND SUPPLIES. Tested and approved for preschool, school, home. Association for Childhood Education International, 3615 Wisconsin Avenue, N.W., Washington 16, D.C. Bulletin No. 39. 1961 revision. 116 pp. 50 cents.

A guide for administrators, teachers, and parents in the selection of play and educational equipment.

CREATIVE DRAMATICS. Association for Childhood Education International, 3615 Wisconsin Avenue, NW., Washington 16, D.C. 1961. 48 pp. 75 cents.

Five articles which illustrate the use of creative dramatics to motivate other phases of learning, to build rapport between teacher and pupil, and to teach children to think independently and to communicate ideas confidently.

SCHOOL SEGREGATION, NORTHERN STYLE. Will Maslow and Richard Cohen. Public Affairs Pamphlets, 22 East 38th Street, New York 16. Public Affairs Pamphlet No. 316. 1961. 20 pp. 25 cents.

This pamphlet points up the growth of racial segregation in the schools in the metropolitan centers of the North and the resulting inequalities in educational opportunities. It attributes the situation to patterns of residential segregation and school districting which have developed over the past 3 decades in the large cities of the North as Negroes have flowed into them from the South. The pamphlet also outlines a few Northern desegregation programs.

EXPLORING THE BRAIN OF MAN: in search of the prevention and cure of neurological and sensory disorders. National Committee for Research in Neurological Disorders, University Hospital, University of Minnesota, Minneapolis 14. 1961. 28 pp.

Developments in research devoted to neurological and sensory disorders—from the use of ultrasounds in brain surgery to millipore filters in nerve regeneration—are broadly scanned in this illustrated booklet.

IN THE JOURNALS

The Mother's Acceptance

A low but positive correlation between a mother's degree of acceptance of her retarded child and her religious background was found in a study reported in the September 1961 issue of the quarterly, *Child Development*. ("Maternal Acceptance of Retarded Children: a Questionnaire Study of Attitudes and Religious Background," by G. H. Zuk, Ralph L. Miller, John B. Bartram, and Frederick Kling.) The authors are the psychologist, the chaplain, and the pediatrician-director of the retardation clinic of the nondenominational St. Christopher's Hospital for Children in Philadelphia, and a consulting statistician.

The study was based on the responses to 72 out of 125 questionnaires sent to mothers of clinic patients—about half Catholic and half non-Catholic and of similar educational and socioeconomic background.

Mothers with higher ratings of intensity in religious practices were found more often to express attitudes regarded by the investigators as revealing a greater degree of acceptance of their retarded children than others; and more Roman Catholic than non-Catholic mothers fell into this category.

The authors relate their findings to the context of Roman Catholic doctrine, which they describe as being more explicit than non-Catholic religious doctrine on absolving parents of guilt for bearing handicapped children.

Therapeutic Love

A British psychiatrist examines his own role as visiting consultant to residential schools for maladjusted children, in the July 1961 issue of the quarterly, *The British Journal of Criminology*. ("Psychiatric Treatment of Children in a Residential Setting," by C. L. C. Burns.) As he depicts it, the role calls for tact, patience, and the ability to give and obtain cooperation and to adapt to the various types of schools and variations in their wardens' philosophies, which range from "good common sense" to the tenets of dynamic psychology. Such differences he says do not count so much in helping a child as the difference in the staff's having or not having the gift of "therapeutic love."

The author, who is associated with the Birmingham Child Guidance Clinic, analyses some cases of children he has seen in a hostel which he visits fortnightly—having tea with the boys, discussing cases with the warden, but seldom seeing the boys individually. He makes the point that even curtailed or sporadic contact with the child can yield good results, but adds that the main therapeutic agent is the life in the school. Followup, he says is essential.

Family Mobility

Noting that a family's change of residence can produce some degree of emotional trauma in a child, a team of authors writing in the quarterly, *Mental Hygiene*, of October 1961 contends that the damage may be more than temporary to children already anxious about intrafamilial relationships. ("The Effects of Family Moves on Children," by R. E. Switzer; J. C. Hirschberg; L. Myers; E. Gray; N. H. Evers; and R. Forman.) Parents becoming unavailable to the child emotionally because of their own unconscious resistance to the move are among other factors identified as aggravating a child's feelings of loss and fear of the unknown.

The authors were members of a subcommittee on the mental health of children of a Kansas fact-finding committee for the preparation of the White House Conference. Drawing attention to a report that, on the average, one out of every four families in the Nation changes homes every year, they advise that parents intending to move take action to prevent emotional difficulties in their children by telling them about the move themselves as far in advance as possible, by continuing to provide them with emotional support at home, by understanding the child's need for support from positive forces outside the home—as in school or scout troop—and considering how some of these forces can be carried forward or counterparts found during the adjustment.

Forgotten Children

In the October 1961 issue of the quarterly, *Social Work*, one of New York City's school social workers describes an experiment in providing 10 cases of disturbed children with direct therapy in the school. ("Therapy with Children Without Parental Involvement," by Sonia Wachstein.) The parents of the children, she says, were hardly or not at all available for interviews, because of "their own overwhelming difficulties," but consented to the therapy in school for their children. The treatment consisted of weekly 1-hour sessions and lasted from 4 months to 2 years. The school, the author maintains, was advantageous as a setting for the therapy, since in providing the insufficiently individualized child with "his own special teacher" it thereby provided him with ego support.

The author points out that private agencies which provide therapeutic services for disturbed children are becoming more and more selective about intake, sometimes requiring involvement of the whole family. She warns that, the "forgotten" children cut off from treatment because their parents cannot participate, may force public attention later, "when it is too late."

Social Matrix of Theft

The October 1961 issue of the quarterly, the *American Sociological Review*, describes a study applying a "self-report" questionnaire designed for studying misconduct among high school students to 912 seventh and eighth graders in three diverse Kansas communities, and correlating the results in relation to the amount of stealing reported. ("Social Correlates of Early Adolescent Theft," by Robert A. Dentler, Dartmouth College, and Lawrence J. Monroe, University of Chicago.)

Major findings were that stealing was self-reported by a greater proportion of boys than girls; of youths 14 years of age or older, than those younger; of youngest siblings, than oldest siblings.

No significant association appeared between theft score and socioeconomic status, type of community, family intactness, peer group sociometric status, or self-concept.

READERS' EXCHANGE

YARROW: *Other research*

There has been sufficient research by enough different investigators to make it reasonably safe to conclude that the employment of mothers is not in all cases detrimental to their children. Since we cannot afford to do a research project on each individual family, emphasis has shifted to the effects of employment under specified conditions or in relationship to significant variables in the environment or within the individual, as in the study described by Marian Radke Yarrow in the November-December 1961 issue of CHILDREN. ["The Effects of Maternal Employment on Children."]

Dr. Yarrow has mentioned the importance of considering intervening variables. I would point out that some antecedent variables or conditions may be equally or more useful. The concept of "contingent condition" is, I feel, a more flexible research concept, which permits the use of both intervening and antecedent variables. In addition to education of the mother, which Dr. Yarrow employed as a third variable, I have found it useful to consider the age of the mother, number of children in the family, whether or not the marriage is her first, length of employment, attitude of the husband toward her employment, and type of position held by the mother. Robert Blood has recently employed income level of the husband to advantage in his analyses. (Blood's article, my own research and the other presently unpublished research referred to here, will be available shortly in a book tentatively titled "The Employed Mother in America," by Ivan Nye, Lois Hoffman, and others, Rand-McNally, 1962.)

How mothers can work a full day and still provide adequately for children's physical and emotional needs is an interesting question. Joseph Perry throws some light on this matter in his recent study of mother substitutes published in the November 1961 issue of *Marriage and Family Living*. He found that if the mother substitute was not a relative, she was likely to be a neighbor. He found less negative material in the attitudes and relationships of mother substitutes toward the children than among the mothers themselves.

Feld, at the University of Michigan, as well as Professors Joseph Perry, Richard Ogles, and myself have found less negative material in the mother-child relationship of employed mothers than of nonemployed mothers. These findings lend support to the idea that mother-child contacts can be *too* close and continuous.

Dr. Yarrow proposed research on the effects of employment on the mother herself. Some research has been done by Professors Sheila Feld, Lawrence Sharp, and myself, but more is needed. Considerable attention is also being directed to the husband-wife relationship.

I agree with Dr. Yarrow that employment of the mother represents a basic change in the structure of the family. Her work role occupies more of her time than any other; furthermore, it is a dominant or rigid role which will affect her domestic roles more than her domestic responsibilities will affect her role as an employee. This subject will continue to challenge some of our ablest researchers.

F. Ivan Nye
Professor of Sociology,
Florida State University

CONANT: *Some suggestions*

I read with great interest and concern the article which appeared in the September–October 1961 issue of CHILDREN entitled "Social Dynamite in Our Large Cities," by James B. Conant. The problem of large numbers of out-of-school, unemployed youth, as Dr. Conant shows, is an appalling one, and I am afraid will be so for some years to come. Here in Cleveland we are attempting to do something about this group with $3,700 donated by the Cleveland Foundation for a survey to be conducted by the school system.

While this is commendable, I believe it must be further enlarged upon and improved upon. Perhaps other cities like New York, St. Louis, Chicago, and Philadelphia are already doing more, but I believe the following steps should be taken:

1. The director of the State employment service should set up a separate unit within the service to deal with the young people between the ages of 16–21 who are out of school and out of jobs.

2. Data on the out-of-work youth should be gathered by the Bureau of Employment Security, U.S. Department of Labor, and the figures released to the press at the same time as the overall unemployment figures, but under a separate heading.

3. The State government should set up a committee composed of labor leaders, educators, and the director of the employment service to deal with the problem.

Dr. Conant pointed out that 300,000 jobs are needed to take care of these young people and this should be pointed out to the President of the United States.

This is a serious problem and a grave situation for America to be in at a time when there are groups busy sowing the seeds of discontent, disunity, and moral decay among our young. It is imperative for whole communities to become interested for this is not a school problem. It is a community problem that must be faced squarely and by coordination and cooperation among groups.

Paul W. King
Lakewood, Ohio

Somebody's business

Dr. Conant has done a great service for the country in pointing up the needs of young people who drop out of school and have difficulty in finding work. Through his speaking and writing he has made the public aware, as it has never been before, of the urgency for some city schools to adjust their programs to educate this group. He has also helped the public become aware of the high unemployment rate among young people and the need for more services for unemployed youth. The rate of unemployment in some slum areas inhabited largely by Negroes is truly alarming. Dr. Conant is helping to focus the attention of many more people on this problem and providing inspiration to those who have over the years been seeking solutions for it.

But it isn't—strictly speaking—true that "the employment of youth is literally nobody's affair." Every State employment service in the country provides special services for youth. Last year nearly 750,000 young people under 20 were placed in jobs by these agencies' local offices—not counting those placed on farm jobs. Services by the public employment agencies have been constantly extended and improved over the last 10 years. We are happy to say that this year additional funds have been made available by Congress for this purpose. Social agencies interested in youth will be glad to know of these improved placement programs for youth and should urge unemployed youth to keep their applications active with the local office of their State employment service.

Plans are underway for youth specialists in the local public employment offices to increase their efforts for counseling and placement of these out-of-school unemployed youth in jobs.

Some local offices of the employment service do have special youth units as Mr. King recommends in his letter. His suggestions and others are being reviewed currently within the Bureau of Employment Security and we hope that in the near future the results of improved employment services for youth will be felt within every large community of the country.

Evelyn Murray
Chief, Branch of Services to Youth, Bureau of Employment Security, U.S. Department of Labor

BLAKE: *A basic difference*

The immediate goals of the youth worker and the police are not identical, and that is the hub of most of our conflicts. The issue is further compounded by the fact that the means of attaining these goals are somewhat difficult though at times running parallel and rather close. There is a failure to understand and admit that the philosophies of social work and law enforcement, even though their ultimate goals are the same, are basically different in respect to how these goals are achieved. This is usually the greatest irritant.

The example given in Mary Blake's article ["Youth Workers and the Police," CHILDREN, September-October 1961] points up very clearly that the immediate goals of each are opposed. The youth worker's goal in this instance is to gather the group together. The policeman's goal is to disperse. Circumstances alone contribute much to creating the dilemma. However, the failure of the youth worker to recognize the hazards of gathering such a group on the corner and the policeman's poor approach added to the provocation. The errors committed by both are so fundamental that there is a tendency to overlook the obvious and suggest the more complex solution.

What is needed today is a bible to be put in the hands of the youth worker and the police explaining in great detail the relative positions of both and how they can get together and how they can best work together. However, even though their efforts are parallel, they should never be permitted to merge because in losing their individual identity, their separate worth is endangered.

The subject of the interchange of information between the youth worker and the policeman to the detriment of an individual person is a very sensitive one. The policeman is duty bound and has a legal obligation to act upon information and to pursue it assertively through investigation, apprehension, and prosecution, and has little legal discretion to act otherwise; whereas, the youth worker, except when heinous and atrocious crimes have been committed, or when required to report by State statute, is guided by the ethics of his profession and his individual moral standards.

Howard R. Leary
Deputy Commissioner, Police Department, City of Philadelphia

ADAMS: *Author's comments*

Although I might differ slightly with her emphasis, I think Hannah Adams has done a fine job in summarizing the study of unmarried mothers made by the Community Council of greater New York under my direction. ["Two Studies of Unmarried Mothers in New York City," CHILDREN, September–October 1961.] I should like, however, to add some of my own observations on the subject.

These observations arise out of the many discussions I had during the development, planning, and execution of the Council's study with professional and lay persons active in agencies serving unmarried mothers. Two recurrent themes were evident in these discussions. I cannot recall a meeting when someone did not say, "But there are many more unmarried *white* mothers than the figures show; and the babies of these mothers are being placed through 'black market' or 'grey market' channels," or "Your study is not really very useful because the important thing is how do we reduce the volume of illegitimate births."

In my view, the attitudes reflected by such comments constitute a deterrent to the further development of agency services to assist unmarried mothers—as they are, and as they will be.

Of course, I would also like to see a reduction in the volume of illegitimate births, but since for a variety of demographic, social, and economic reasons there is little prospect of such a reduction in the next decade, I believe the more important immediate task is to help those women who are or will become unwed mothers (and their children) in the ways that they need help. In the main, these are women of minority groups and of relatively low socioeconomic status. Some lessening of the preoccupation of social agency personnel with the "undiscovered" white unmarried mothers is essential if we are to get the necessary shift in emphasis which hopefully will lead to the expansion of services for the unmarried mothers in full view on our doorsteps.

Blanche Bernstein
Formerly Director of Research, Community Council of Greater New York

More controls needed

In reading the article by Hannah Adams, "Two Studies of Unmarried Mothers in New York City," we are again reminded of two points that should be taken into consideration in conducting or interpreting research in this area. First is the difficulty of arriving at meaningful conclusions about unmarried motherhood without taking into account some of the relevant background characteristics. For example, while the studies show that the illegitimacy rates vary greatly by race and ethnic background, as Miss Adams points out, other factors in socioeconomic status were not used as a control in analyzing the data. It is likely that much, if not all, of the differences found between married and unmarried mothers with respect to amount and

type of prenatal care, infaut mortality, and so on, would have disappeared if the data had been controlled for socio-economic status, broken home background, and other variables which might be considered as more basic than the marital status of the mother.

Such factors could even account for much of the well-publicized rise in the rate of births out of wedlock, since there have been large shifts in the proportion of urban population and composition of the population by race and ethnic background, socio-economic status, occupation of father, employment of mother, and other variables which correlate with amount of premarital pregnancy. These shifts in population composition could result in a rise in the total illegitimacy rate even without change in the rates for various subgroups. Such distinctions should have important implications for the way we conceptualize the problem of unmarried motherhood and the kinds of solutions we propose.

The second point I would like to make deals with the notion of the "need for assistance." The need for medical care is well established. The need for other kinds of social services to aid in the social and economic adjustment of the unmarried mother and her child is not so well established, but likely to be assumed by persons dealing with such matters on a professional level. That assumption should be examined more carefully.

In many types of cases there are obvious and serious crises, not always met, as is well documented in the studies discussed here. For others, aside from the affront to our dominant moral codes, the crisis to the individuals may be minimal or nonexistent. In many cultures, unmarried motherhood is not unexpected and is apparently accompanied by no penalties to mother, child, family, or community. The same may be true, to a degree, among some subgroups in this country.

Instead of assuming a crisis, we might find it useful to examine the kinds of situations in which a crisis does exist and to define the crisis in terms of the effect on the mother, on the child, and on the family of the mother. This is not to overlook the community problems that inevitably arise, but these may often be more fruitfully dealt with in terms of the basic social and economic problems of the family or group in which the unmarried mother lives rather than in terms of unmarried motherhood itself.

Charles E. Bowerman,
Professor, Department of Sociology and Anthropology, The University of North Carolina.

MEYER: *Author's response*

I was delighted to see in the Readers' Exchange section of CHILDREN (September–October 1961) Mary Schuster's thoughtful response to my article ["A Development Program for Child Welfare Staff," CHILDREN, July–August 1961.]

Miss Schuster was right in saying that I did not make clear whether or not our demonstration project is intended to become a permanent part of the agency's program. It has, of course, been our hope from the beginning of the project that a successful demonstration would lead to the establishment of the position of a permanent director of staff development. I agree that without definite responsibility assigned to one person for the administration, coordination, and general direction of a staff development program, it would indeed be "whittled away here and there to 'adjust to an emergency', until little is left." I would go even further and say that if one person is *not* charged with staff development responsibility in an agency, professional leadership would soon wane as there would be no one responsible to bring together educational materials and agency practice.

Regarding Miss Schuster's recognition of our discouraging staff turnover in New York City, I can only express appreciation for her awareness of how devastating this factor is to staff development as well as to agency practice. The staff situation in New York City is probably very different from that in Wisconsin where, Miss Schuster says, the agency can "wait for properly qualified staff." Here, we would have a much longer wait, and, therefore, we have had to concentrate on methods that will succeed in retaining even our nonqualified staff.

As far as our stipend program is concerned, we have only participated in the Child Welfare Service Scholarship Program for 2 years. For 10 years before, the Bureau of Child Welfare had a work-study program which proved to be unsatisfactory as far as staff retention was concerned, because it only provided for the first year of graduate school. Therefore, we lost many of our work-study students to other agency scholarship programs when they had fulfilled their work commitments with us. We anticipate being able to retain our 2-year scholarship graduates with increased salaries and carefully planned job assignments. We, of course, envy the Wisconsin agency their 70 percent trained staff. In New York City, in the Bureau of Child Welfare alone, 70 percent of our staff would equal about 400 people, a figure which is completely unrealistic to hope will represent our professional staff in the near future.

Except for these considerations, the steps Miss Schuster outlines toward building a professional staff are certainly unarguable.

Carol H. Meyer
Director of Training, Bureau of Child Welfare, New York City, Department of Welfare

FOR PARENTS

DR. SPOCK TALKS WITH MOTHERS; growth and guidance. Benjamin Spock, M.D. Houghton Mifflin Co., Boston. 1961. $5.

TEACHING YOUR CHILD RIGHT FROM WRONG. Dorothy K. Whyte. Bobbs-Merrill Co., New York. 1961. 192 pp. $3.50.

THE MENTALLY RETARDED CHILD AND HIS PARENT. Stella Stillson Slaughter. Harper & Bros., New York. 1960. 174 pp. $3.75.

HELPING YOUR GIFTED CHILD. Ruth Strang. Introduction by Cyril William Woolcock. E. P. Dutton & Co., New York. 1960. 270 pp. $4.50.

THE ONLY CHILD. Eda J. LeShan. Public Affairs Pamphlet No. 293. Public Affairs Committee, 22 East 38th Street, New York 16. 1960. 20 pp. 25 cents. Discounts on quantity orders.

IF YOUR CHILD HAS A CONGENITAL HEART DEFECT. American Heart Association, 44 East 23d Street, New York 10. 1960. 47 pp. Obtainable without charge from the association or from local heart associations.

SOME U.S. GOVERNMENT PUBLICATIONS FOR PROFESSIONAL WORKERS

Publications for which prices are quoted are for sale by the Superintendent of Documents, U.S. Government Printing Office, Washington 25, D.C. Orders should be accompanied by payment. Twenty-five percent discount on quantities of 100 or more.

RURAL HEALTH: selected annotated references, January 1953 to June 1960. Department of Agriculture, Economic Research Service, and Department of Health, Education, and Welfare, Public Health Service. 1961. 39 pp.

Directed to workers in research, health education, community activities, and other health work in rural areas, this compilation of annotated references lists readings in trends affecting rural health; health resources and their use; personal health care expenditures and financing; social factors affecting the use of health resources; community study action programs; and special population groups—such as agricultural migrants and Indians.

GUIDE FOR PUBLIC HEALTH NURSES WORKING WITH CHILDREN: from the developmental point of view. Martha M. Borlick. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. CB Publication No. 392. 1961. 35 pp. 20 cents.

Among the facets of a public health nurse's work with children, that are considered in this publication are: case-finding; recording; analysis of families and their physical setting and neighborhood; appraisal of the mental, physical, and social development of boys and girls; and the formation of plans for working with families, including suggestions for building up rapport with the members of the family. The author is a public health nursing specialist with the District of Columbia Department of Public Health.

UNMARRIED PARENTS: a guide for the development of services in public welfare. Reba E. Choate and Ursula M. Gallagher. Department of Health, Education, and Welfare, Social Security Administration, Bureau of Public Assistance and the Children's Bureau. BPA Report No. 45 and CB Publication No. 390. 1961. 63 pp. 30 cents.

This pamphlet spells out the responsibilities of the State agencies for providing for the care and protection of unmarried parents and their children. It points up the importance of coordination of services within the public welfare department; review and, if necessary, revision of legislation, policies and procedures affecting the quality of service provided unmarried mothers; planning for effective use of consultants in helping localities improve their services; strengthening working relationships among all agencies of State government with programs affecting unmarried parents; preparation of materials for local agencies on the social, health, and legal services needed by unmarried parents; and making the legal rights of out-of-wedlock children and their parents clear to local agencies and the general public.

THE INTERNATIONAL ACTIVITIES OF THE CHILDREN'S BUREAU. Sarah S. Deitrick, M.D., and Dorothy E. Bradbury. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. 1961. 20 pp. Single copies available from the Bureau without charge.

This pamphlet reviews the international activities carried out by the Children's Bureau since their beginning in World War I—when studies of the programs of child welfare in the warring countries were made—to the Bureau's broad, diversified program of today.

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MARCH • APRIL 1962

children

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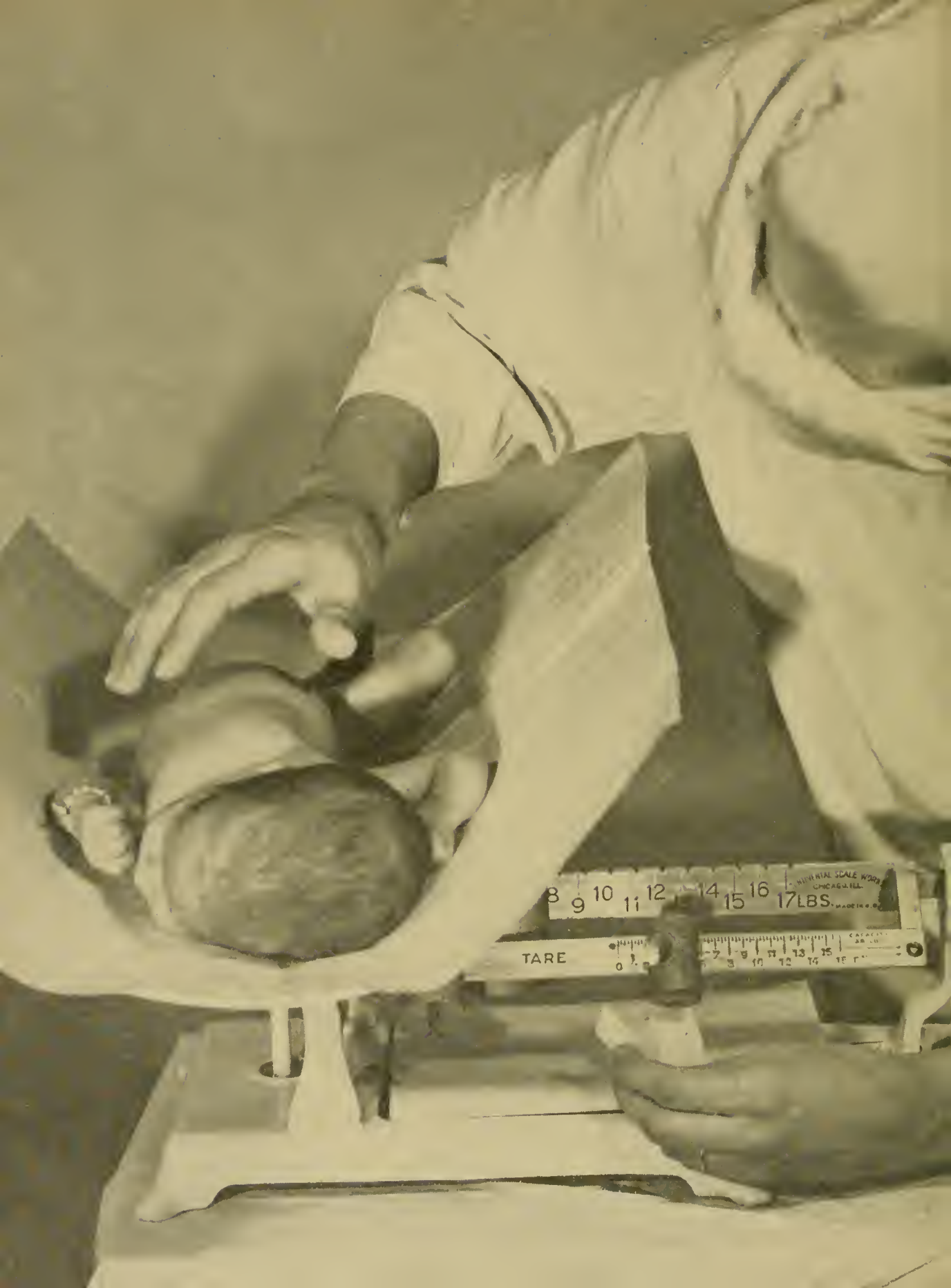
THE NEEDS AND PROSPECTS OF CHILDREN AND YOUTH

yesterday, today, and tomorrow

50th ANNIVERSARY CHILDREN'S BUREAU 1912–1962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THE SHAPE OF THE FUTURE lies with this child, as with each new life as it comes into the world. What he makes of it will depend largely upon the nurture and guidance he receives along the way. The goal of the Children's Bureau is to broaden his and all children's chances for a healthy physical and emotional development—the Bureau's steady goal since Congress passed the act creating the Bureau in 1912. In celebration of this 50th anniversary, CHILDREN presents here a special issue—looking backward briefly at the concepts and events which have shaped the Bureau's activities over the years, but focusing mainly on the children of today, their needs, and their prospects for the future.

An anniversary celebration will be held on April 9 at the Statler Hilton Hotel in Washington, D.C., with the First Lady, Mrs. John F. Kennedy, as honorary chairman.

◀ *the authors*

In addition to his private practice and his hospital work, Dr. Gold serves as senior obstetric consultant to the New York City Department of Health. He also teaches at the New York Medical College, and New York's State University of Medicine Downstate Medical Center, and is visiting professor at the Harvard School of Public Health.

Before becoming Commissioner of the New York City Department of Health 8 years ago, Dr. Baumgartner had 15 years of service with the Department in various capacities mainly concerned with maternal and child health. A former associate chief of the Children's Bureau (1949–50), she has written over 150 articles for scientific journals.

Dr. Mayo (left) took his present post 12 years ago. Previously he had been for 8 years with Western Reserve University, first as dean of the School of Applied Social Sciences, then vice-president. Mr. Reid (right) went to the Child Welfare League in 1950 from the Ryther Child Center, Seattle. He became director in 1953.

A psychologist trained at the Iowa Child Welfare Research Station and Washington University, Dr. Caldwell (left) is working with Dr. Richmond (right) on a study of interpersonal aspects of infant learning. Dr. Richmond, a pediatrician, has been a medical educator since 1946, having taught at the University of Illinois College of Medicine before going to Syracuse in 1951.

For more than 25 years, Eli Cohen (left) has worked professionally with vocational problems of youth. A consultant on youth employment to the U.S. Department of Labor, he also serves on official New York City advisory groups on youth work. Louise Kapp (right) directed public relations for the Conference on Unemployed Out-of-School Youth in Urban Areas, held in Washington in 1961.

Before assuming her present position in 1957, Mrs. Sinclair was for 10 years Canadian delegate to UNICEF, during which she was twice chairman of its executive board. An economist, she was for 10 years executive assistant to Canada's Deputy Minister of Welfare and has been a delegate to the United Nations Assembly.

A HALF CENTURY OF PROGRESS FOR ALL CHILDREN

KATHERINE B. OETTINGER
Chief, Children's Bureau

THE SWEEP OF HISTORY is measured not only by the needs, issues, events, and crises of any era, but by the interactions of personalities, tenets, underlying programs, and the concepts of the times. Therefore, the significance of the 50-year history of the Children's Bureau may be best perceived by dividing it into five periods, corresponding to the tenures of each of the five chiefs.

The establishment of the Bureau marked the point where the Federal Government first took responsibility for promoting the welfare of individuals. As we briefly encompass the highlights of the Bureau's history, we may gain perspective on its mandate for the future.

Early in this century some vocal pioneers began to express the belief that children, as the Nation's most important resource, were worthy of the attention of a special agency of the Federal Government devoted to finding and disseminating facts related to their health and welfare. This idea was nourished by the White House Conference on Care of Dependent Children, called by President Theodore Roosevelt in 1909.[1] By April 9, 1912, under the administration of President William Howard Taft, the idea had matured into a Federal law establishing the Children's Bureau and charging it to investigate and report "upon all matters pertaining to the welfare of children and child life among all classes of our people."[2] The new Bureau was placed in the then Department of Commerce and Labor.

This law directed the Bureau to have special concern for "infant mortality, the birth rate, orphanage, juvenile courts, desertion, dangerous occupations, accidents and diseases of children, employment, legislation affecting children in the several States and Territories."[2]

THE FIRST CHIEF 1912-1921

The first move of the Bureau's first Chief, Julia C. Lathrop, appointed by President Taft, was to call together a group of concerned people to consider priorities in its program.

A study of infant mortality was selected as a starting point.

To determine the reasons for the high death rate among infants—estimated to be about 125 per 1,000 live births in 1912—the Bureau conducted investigations in nine cities beginning in 1914.

These studies showed that the greatest proportion of infant deaths was associated with conditions that could be remedied with community action: Death rates of babies went down as fathers' earnings went up. More breast-fed babies survived the first year than bottle-fed babies. Babies with their mothers in the home had a better survival rate than babies deprived of their mothers' care. Sanitary conditions were important factors.

These findings gave great impetus to the drive for improved sanitary conditions in communities and for extending the pasteurization of milk. They were used as arguments for minimum wage legislation and for mothers' pensions. They prompted Miss Lathrop to present in her 1917 report a plan for the "public protection of maternity and infancy"—a plan to provide Federal aid to the States for maternity care to mothers and infants.

In support of this plan, she said:

> In large areas of our country . . . we are confronted by poverty and by isolation. There are areas far removed from doctors, where the visiting nurse is unknown, where hospitals are inaccessible . . . and in these regions mothers and babies suffer and die unattended. There are industrial areas, too, where mothers and children are treated with fatalistic neglect. These mothers and these children need public health nurses, hospitals, and medical attention . . . These things should be provided as the public schools are provided, to be used by all with dignity and self-respect. Such provisions can be secured by Government aid to States on the plan already in operation for aid to agriculture, vocational training, good roads, protection against venereal diseases.[3]

From the very beginning, Miss Lathrop foresaw many of the directions the Bureau was to travel.

Said her first annual report:

> The final purpose of the Bureau is to serve all children, to try to work out the standards of care and protection which shall give to every child his fair chance in the world. It is obvious that the Bureau is to be a center of information useful to all the children of America, to ascertain and to popularize just standards for their life and development . . . Thus all service to the handicapped children of the community . . . also serves to aid in laying the foundations for the best service to all the children of the Commonwealth.[4]

With this sense of responsibility to "all children" the Bureau undertook its early studies of the health, economic, and social conditions of children—institutional care, juvenile delinquency, child labor, feebleminded children, crippled children—and began, in 1913, its popular series of bulletins for parents. The first of these bulletins, "Prenatal Care," appeared in 1913, followed in 1914 by the first edition of the Government's bestseller, "Infant Care."

After World War I, Miss Lathrop induced President Wilson to call the White House Conference on Standards of Child Welfare, held in 1919, thus establishing the precedent of having White House conferences on children every 10 years.[1] Miss Lathrop also established the precedent of extending the Bureau's interest in the well-being of children to those of other lands when she helped organize the first Pan American Child Congress, held in Buenos Aires in 1916.

Grace Abbott succinctly summed up her predecessor's leadership:

> From the beginning, Miss Lathrop's program of work for the Bureau set up prevention as the goal. She held that, as a democracy, the United States must seek continually new ways of insuring the optimum growth and development of all American children. But the existing temporary importance of palliatives was never ignored. . . . The slow scientific accumulation of fundamental, basic information about children and child life was begun in no narrow or timid spirit by Julia Lathrop. She was prepared to go wherever the interests of the child might lead her and to accept whatever conclusions flowed from an honest interpretation of facts assembled with meticulous accuracy.[5]

THE SECOND CHIEF 1921-1933

In August 1921, Julia Lathrop was succeeded as Chief by Grace Abbott. During Miss Abbott's tenure, the Bureau had its first experience in administering a grant-in-aid program, the Maternity and Infancy Act of 1921 (the Sheppard-Towner Act).

This act was a direct outgrowth of Miss Lathrop's earlier plan. Under it Federal grants were given to the States for strengthening services and standards of maternity and infant care.[6] This short-lived program provided the Bureau with knowledge and experience useful later in laying the foundation for the maternal and child health program of the Social Security Act. Other Bureau activities under Miss Abbott which contributed later to the planning for the children's provisions of the Social Security Act were its studies of State and local programs of mother's aid, foster care, adoption, and care of crippled children. The Bureau's interest in children around the world was expressed by Miss Abbott's membership on the League of Nations Advisory Committee on Traffic in Women and Children and her service as secretary of the committee on children for the first conference of the International Labour Organisation.

But the Bureau's major efforts under Miss Abbott were concentrated on the effects of economic depression on families and children. Its studies in this

regard began during the "hard times" of 1921–22, and intensified during the early years of the great depression of the thirties. They focused on: (1) the effect of unemployment on families and children; (2) the extent and adequacy of relief as financed by private charity and public funds; (3) the extent and adequacy of State mother's aid (or widow's pension) programs; and (4) the lot of growing numbers of jobless, transient, young people.

A deep concern over the effects on the health and welfare of children of the widespread economic want ran through the deliberations of the White House Conference on Child Health and Protection called by President Herbert Hoover in 1930. Early in 1931, Miss Abbott made one of her many courageous pleas for Federal assistance to the needy.

Pointing out that public relief, being almost entirely locally financed, was inevitably inadequate in the most depressed communities, she said: "Those who know our relief machinery and the available resources for relief cannot share the optimism of those who say that no one will be hungry or cold this winter." [7]

Seeing the State programs of mother's aid as a possible channel for helping the unemployed, she wrote on another occasion:

> I hope that a number of States will be willing to try the experiment of adding unemployment to the list of conditions on which mother's assistance can be given. I hope some of them will plan to give the relief before the family has passed over into the abyss of destitution, before their last possessions and their independence are gone.[8]

Rumors that unprecedented numbers of boys and girls had taken to the road in search of work began to reach the Bureau during the fall of 1931. The following spring, the Bureau undertook to find out the facts. Information was obtained through correspondence with chiefs of police and executives of community chests and councils of social agencies in 25 cities and through visits to parts of the Middle West, the South, and the Far West. The findings showed that in community after community, the transient youth was an unwelcome visitor. A dish of beans grudgingly given, a place to sleep on the jail floor, and an invitation to leave town by morning were his usual lot.

"It is costing large sums to provide this kind of merry-go-round care," Miss Abbott told a congressional committee, "but the social cost of the future will be much greater." [9]

She suggested using public funds to provide these young people with work opportunities, an idea later embodied in the Civilian Conservation Corps and the National Youth Administration.

The grimness of depression days dimmed neither Miss Abbott's sense of humor nor her determination to keep concern for children from being submerged in the Washington whirlpool:

> Sometimes when I get home at night in Washington I feel as though I had been in a great traffic jam . . . moving toward the Hill where Congress sits in judgment . . . In that traffic jam there are all kinds . . . of conveyances, for example . . . (the Army's) tanks, gun carriages, trucks . . . the hayricks and the binders and the ploughs . . . (of the Department of Agriculture) . . . the handsome limousines in which the Department of Commerce rides . . . the barouches in which the Department of State rides in such dignity. It seems so to me as I stand on the sidewalk watching it become more congested and more difficult, and then because the responsibility is mine and I must, I take a very firm hold on the handles of the baby carriage and I wheel it into the traffic.[10]

THE THIRD CHIEF 1934-1951

In November 1934, President Franklin D. Roosevelt named Katharine F. Lenroot Chief of the Children's Bureau. She served during the remaining years of the great depression, the defense and war years, and the immediate postwar years.

During the years 1934–40, the Bureau concentrated on building the maternal and child health, crippled children, and child welfare programs under the Social Security Act of 1935, first helping to mold the act and then planning for and initiating the administration of these three programs as provided for in its Title V.[11]

The maternal and child health programs authorized grants to the States for extending and improving health services for mothers and children, especially in rural areas and areas suffering from severe economic distress.[6] It also authorized federally supported demonstrations to be part of the program in each State.

The crippled children's program authorized grants to the States for diagnostic and treatment services for children with handicapping illnesses. The

child welfare services program provided for "establishing, extending, and strengthening, especially in predominantly rural areas," services for the protection and care of "homeless, dependent, and neglected children and children in danger of becoming delinquents."

The provision of these services, wrote Miss Lenroot, constituted "recognition . . . that security and opportunity for children are dependent not alone upon family income but also upon parental intelligence and understanding and community provision for the health and social services which individual families, under modern conditions, cannot provide singly." [12]

In getting these programs underway, the Bureau characteristically turned to advisory groups for guidance. In addition, special committees on various technical problems were appointed. The States were also consulted on all phases of the program.[13]

In the health programs, the Bureau promoted the concepts of treating the whole child rather than a specific disability and of providing services through a team of professional workers of a variety of disciplines. In the child welfare program it especially stressed the use of Federal funds for the employment and training of professional personnel.

While these programs were getting underway, the Bureau was also studying the unemployment problems of youth and the effects of the Agricultural Adjustment Act and the Sugar Act of 1937 on alleviating child labor in industrialized agriculture; drafting the child-labor restrictions of the NRA codes; administering the child-labor regulations of the Fair Labor Standards Act [see page 79]; and serving as secretariat for the White House Conference on Children in a Democracy, held in 1940.[1]

The Second World War brought the Bureau a special program called Emergency Maternal and Infant Care, usually known as EMIC. This program was the largest public maternity program ever undertaken in the United States. It provided wives of aviation cadets and of servicemen in the fourth to seventh grades of all the services free medical, nursing, and hospital care throughout pregnancy, at childbirth, and for 6 weeks thereafter. It also provided for medical, nursing, and hospital care for the babies of these servicemen during their first year.

From the beginning of EMIC in 1943 to its 1949 demise, approximately 1,222,500 mothers were given maternity care and approximately 230,000 infants received medical care at a total cost of $126,922,316.

Shortly after the country began to prepare for defense, the Bureau began to get reports about children being left at home alone or locked in parked cars while their mothers worked. The increased employment of women in industry created a widespread need for day-care services for children of working mothers. Therefore, during July 31–August 1, 1941, the Bureau brought together a group of experts in the field of child care to discuss ways of meeting this need. Shortly after, the War Manpower Commission directed the Office of Defense, Health, and Welfare Services, in consultation with appropriate departments and agencies of the Federal Government, to help the States promote and coordinate day-care programs. To this end, $400,000 were made available from the President's Emergency Fund. Under this program, 28 plans administered by State departments of public welfare went into operation after approval by the Children's Bureau and 33 plans administered by State departments of education after approval by the Office of Education. After these funds expired June 30, 1943, funds were made available under a special War Area Child Care Act, known as the Lanham Act for day-care programs in war impact areas.

At the peak of the wartime day-care program, July 1945, approximately 1,600,000 children were enrolled in nursery schools receiving Federal funds. Federal support was withdrawn October 31, 1945.

Miss Lenroot continued to urge that the day care problem be dealt with "on long-range not emergency terms . . . "

"Failure to meet this need for day care," she said, "is not only placing an impossibly heavy burden on many women who must work . . . but is also exacting a high toll in the health and welfare of children." [13]

Labor shortages in the wartime forties plunged many unprepared youngsters into adult jobs, often hazardous and taken at the sacrifice of schooling. The Bureau called the Nation's attention to this, through publications, reports, speeches, and testimony at congressional hearings. The framework of State child-labor laws built up over the years largely held up in spite of wartime pressures.

On July 16, 1946, the Bureau, minus its child-labor functions, was transferred from the Department of Labor to the Federal Security Agency.

The period between 1946 and 1951 was spent in shifting from intensive wartime activities to a program of ongoing permanent activities; in working on standards of child care for unaccompanied children being brought to this country from the dis-

placed persons camps of Europe; in participating in the Midcentury White House Conference on Children and Youth;[1] and in working in an advisory capacity with the new international agencies, the United Nations Children's Fund (UNICEF), and the World Health Organization (WHO), and helping the United Nations and our own Department of State in setting up training programs for personnel of other countries. The Bureau also sent consultants to various Latin American countries and arranged for the training here of Latin American personnel.

THE FOURTH CHIEF 1951–1956

Dr. Martha M. Eliot was appointed Chief of the Children's Bureau by President Harry S. Truman on September 4, 1951. Throughout her tenure, all aspects of the Bureau's program were affected by the rise in the child population and by reflection in the lives of children of the mounting tensions of the atomic age.

These pressures, as well as the emphasis on personality development in the Midcentury White House Conference on Children and Youth, stimulated the Bureau to put heavier stress in all its programs on the emotional well-being of children, and the importance of an understanding of child development principles in working with children.

During this period, too, the Bureau increased its demonstration projects for the care of premature infants and encouraged States to give greater attention to prenatal care for mothers with complications of pregnancy. It participated in a study which pinned down the cause of an increase in blindness from retrolental fibroplasia among prematures.

At the same time the Bureau encouraged the States to extend their crippled children's programs to include a variety of disabilities in addition to orthopedic defects.

The Bureau also recruited child-welfare and child-health personnel for our Government's technical assistance programs in other countries and continued to set up training programs in this country for foreign personnel and to work closely with UNICEF and WHO.

But the strong new emphases of the Bureau at this time were in the areas of juvenile delinquency, mental retardation, and adoption. Said Dr. Eliot in 1952:

> About a million children come to the attention of the police for delinquent behavior each year. About 350,000 delinquent children are brought to the attention of juvenile courts.
>
> We know that with understanding help, many of these children can be rehabilitated . . . But the help must come promptly . . .[14]

In July 1952, a Special Juvenile Delinquency Project, financed by foundation and other voluntary funds, was initiated to work with the Children's Bureau in combating juvenile delinquency. Its purpose was to focus attention on problems related to the prevention and treatment of juvenile delinquency and to stimulate appropriate action. Beginning in 1952, the Bureau sponsored five meetings with representatives of about 90 national organizations to discuss ways of stimulating such action. The Bureau also published a series of guides to the treatment of delinquent children, including standards for training schools, juvenile courts, police work with juveniles, and training of personnel for work with delinquents. It also conducted research on the effectiveness of juvenile delinquency programs. The Bureau and the project together sponsored conferences on health services and juvenile delinquency, on new lines of delinquency research and on the role of parents in preventing and controlling delinquency. They also prepared a National Conference on Juvenile Delinquency held in Washington, D.C., June 28–30, 1954,[15] the final activity of the project.

In August 1954, the Congress made funds available to the Bureau for the fiscal year 1955 for expanding its services in the field of juvenile delinquency, and a few months later a Division of Juvenile Delinquency Service was set up in the Bureau.

The Bureau took its first step in service to the mentally retarded in 1954 with a grant to California from maternal and child health funds for a diagnostic clinic to be set up at the Children's Hospital in Los Angeles. In 1955, three other States were granted maternal and child health funds for similar demonstration projects.

That this was an approach needed on a vaster scale was indicated by testimony presented by many parents and professional persons in a hearing before the House Appropriations Committee in 1956, which brought out the importance of early diagnosis, habili-

tative planning, and work with parents in helping the mentally retarded. To this end, the Congress increased the maternal and child health appropriations for the fiscal year 1957, earmarking $1 million for special projects for mentally retarded children, a practice that it has repeated each year since.

At the time Dr. Eliot came to office, evidences of a growing "black market" in babies for adoption were arousing widespread interest. Dr. Eliot was convinced that workers in the social, health, and legal field would have to join forces to eliminate this. Therefore, on June 27–28, 1955, the Children's Bureau called together a group of people representing the fields of health, law, and social work to consider the factors in protecting children in adoption.[16]

Dr. Eliot constantly expressed a deep conviction of the importance of an across-the-board approach to children's problems. Thus, she said:

> Too many of our public and private agencies, our health, social welfare, and education programs, our churches and youth-serving organizations have worked in isolation from each other or with courtesy nods, only, between them. . . . By this very separateness, I am convinced we are either wasting, or not using, tremendous social energy. We are failing to reach countless children who could use some help. By building emotional, as well as brick, walls around our individual institutions and agencies, we are limiting our capacity to help. . . .
>
> To be as bold and inventive as the atomic scientists calls for sharpening our perception of children's needs. Even more, it calls for courage: the courage to face reality, to recognize the implications of what we are doing, or failing to do; the courage to invent, to experiment, and to test new ways of working together.[17]

THE FIFTH CHIEF 1957——

As I look back to April 1957, when I was appointed the fifth Chief of the Children's Bureau, I feel we have made many gratifying advances toward the greater well-being of our children. But we are far from keeping pace with the increase in births, the rapid changes in our culture, and new understanding derived from medical and social research, and have not achieved program coverage throughout the vast reaches of our country. We are heartened that more children than ever have been receiving better services. But this is not enough, especially in a time of accelerating social change.

Many of the tenets so evident in the Bureau's previous years have emerged with even greater clarity. Among those that have been reinforced by developments of the past 5 years are:

1. *Services essential to children's well-being must keep pace with children's needs.*

Congressional recognition of this tenet was reflected in the amendments to Title V of the Social Security Act in 1958 and again in 1960. Each time the authorization was increased for maternal and child health services, crippled children's services, and child welfare services.

Substantial increases followed in appropriations for these programs from $41,500,000 for 1958 to $67,000,000 for 1962, a 62 percent growth. The $75,000,000 appropriation requested by the President for 1963 will again bring the total appropriation to the statutory ceiling.

In 1960 one-third of all registered births were to residents of metropolitan areas, a reflection of the increasing urbanization of our society. To help meet the problems of our urban children and youth, Congress extended the child welfare provisions of the Social Security Act to them in 1958. The Bureau must also respond to population shifts by seeking to build stronger municipal maternal and child health and crippled children's services, especially where voluntary resources are inadequate.

2. *Research findings that could benefit children and their families must be translated into action throughout the country.*

For the first time since 1912 the Bureau had its research authority extended in 1960. A new program of grants for research and demonstration in the field of child welfare was authorized in Title V of the Social Security Act and funds for implementing it were appropriated in 1960. At the same time the child health and crippled children provisions were broadened to permit special project grants to be made directly to institutions of higher learning. Legislation to provide grants for research in maternal and child health is now before Congress.

The International Health Research Act also granted new powers to the Secretary of Health, Education, and Welfare for extending the Bureau's research responsibility. This act authorizes the establishment of fellowships and the making of

grants for international health research which is now being activated in nine countries. International child welfare research has been initiated through the use of counterpart funds.

3. A great variety of trained personnel for children's services is a prime requisite for the advancement and refinement of these services.

The 1961 manpower studies, in which the Children's Bureau cooperated, dramatically spotlighted the seriousness of the shortage of professional personnel in the child health and welfare fields. These facts have given a new impetus to immediate and long-range planning for acceleration of training activities. The Children's Bureau has stepped up its efforts to help the schools of medicine, social work, public health, and the social sciences meet this critical situation. In addition, the further use of auxiliary workers is being explored both in child welfare and health services.

The shocking gaps in available personnel demands not only further Federal legislation for training in both health and welfare fields as recommended by the President, but also the interest and cooperation of many agencies, organizations, and citizens.

4. Programs designed to advance the well-being of children require the cooperation of professions and agencies at all levels.

On many occasions in the years since 1957, advisory groups have added to the richness of Bureau programs. For example, the Advisory Council on Child Welfare Services appointed under a 1958 amendment to the Social Security Act, made recommendations in December 1959 of far-reaching importance.[18] Among the others were a series of advisory groups called in connection with the Golden Anniversary White House Conference on Children and Youth in 1960—first groups representative of specific professions to advise on initiating and planning the Conference, and finally a group representative of many interests to advise on the role and goals of the Bureau and its contribution to the White House Conference followup.

In other instances, advisory groups of specialists have come to the Bureau to discuss specific problems—juvenile delinquency, the use of case aides in child welfare programs, services for mentally retarded children, adoption practices in relation to social workers, physicians, and lawyers.

The Children's Bureau also has stimulated community services for children and youth and new methods of working in this area. It has also been trying to tackle more vigorously the difficult job that true coordination of all programs for the benefit of children requires through followup activities with the State committees on children and youth and Federal departments. The Bureau is also keenly aware of the necessity of bringing a variety of services in closer orchestration to meet the needs of groups of children living in broken families or subject to extreme neglect or danger.

Traditionally the Chief of the Children's Bureau serves as working chairman and the Bureau provides staff for the Interdepartmental Committee on Children and Youth, a coordinating body created in 1948 to work for greater effectiveness in program planning for children. The Committee now represents 34 Federal agencies. The chief also is a vice chairman of the National Committee for Children and Youth, established to attain the goals of the White House Conference.

5. The Nation has a special obligation to remove or alleviate the handicaps suffered by children.

As the child population grows, the number of children with handicapping conditions increases—and they must receive an ever-higher priority in research efforts and in translating the findings into services. For example, because of the extremely high cost of new lifesaving surgery for children with congenital heart disease, State crippled children's agencies in a number of States have been exhausting their funds before the end of the grant period. In 1959, Congress made a supplemental appropriation of $1,500,000 to the Bureau to be used only for services for children with congenital heart disease. The number of children served by the program increased from 2,000 in 1950 to 16,700 in 1960.

Special projects for mentally retarded children have rapidly increased since 1957. Forty-four State health departments now provide diagnostic services for preschool children, including the 31 supported by earmarked maternal and child health grant funds. Fourteen medical schools now use programs to train students in management of the mentally retarded. Since 1957 the Children's Bureau has also been offering the States special consultation on child welfare services for the mentally retarded.

In 1960, the crippled children's program of the Children's Bureau was given the Albert Lasker Group Award for its contribution for helping "four

and one-quarter million children who are handicapped or with conditions which might lead to handicaps."

6. Every child should have a home of his own preferably with his own parents.

All Children's Bureau programs stress the importance of keeping families together if possible.

By 1958 the revolutionary rise of employment among women meant that 4,037,000 children under 12 had mothers who were working full time. In order to find out what was happening to these children, the Children's Bureau requested the Bureau of the Census to make a survey of mothers' child-care arrangements. This survey revealed that 400,000 children under 12 years of age were caring for themselves while their mothers worked full time.

The Bureau intensified its consultation to a variety of public and voluntary agencies about meeting the plight of such children. In November 1959, an advisory committee on day-care services, worked with the Children's Bureau and the Women's Bureau, Department of Labor, to plan the National Conference on Day Care. Held in November 1960, this brought together representatives of labor, industry, and national health, welfare and educational agencies, and others.

Among other steps to encourage the development of day-care services, the conference recommended that Federal, State, and local funds be sought for the purpose. In his recent message to Congress on public welfare programs, President Kennedy declared that adequate care for children during their most formative years is essential to their growth and training. Simultaneously, the Secretary of Health, Education, and Welfare transmitted a welfare bill which included provisions for an appropriation for day care "in order to assist the States to provide adequately for the care and protection of children whose parents are, for part of the day, working or seeking work, or otherwise absent from the home or unable for other reasons to provide parental supervision."

During 1959, a 2-year effort to promote homemaker service reached its climax in a national conference in Chicago, sponsored by 26 organizations and 8 units of the Federal Government. The Children's Bureau is working with the continuing executive committee of the conference to encourage development of new services in the 20 States which have only a few scattered projects and the 23 States with no homemakers at all. These services lead to the preservation of homes.

7. The complexities of society make it necessary for young people to be helped to find their place in the world.

In a society made increasingly complex almost daily by new discoveries and events, growing up can be very difficult. Since this calls for intensified readjustment and new programs for helping youth, the Bureau is now establishing a Youth Development Unit to focus on promoting opportunities for youth.

During the years between 1957 and 1962, as juvenile delinquency continued to mount, the Bureau accelerated its consultation services on technical problems of juvenile delinquency control and treatment. At the direction of Congress, the Children's Bureau and the National Institute of Mental Health submitted a joint report on juvenile delinquency on trends, related factors, means of treatment, control and prevention, and research evaluation and training needs. Out of the Bureau's investigations in relation to this emerged 17 widely used professional publications, "Juvenile Delinquency—Facts, Facets."

The Juvenile Delinquency and Youth Offenses Act of 1961, passed by the Congress in September, authorized $30,000,000 over a period of the 3 following fiscal years for demonstration projects, the training of personnel, and technical services. The provisions of this act are to be administered by the Secretary of Health, Education, and Welfare in consultation with the President's Committee on Juvenile Delinquency and Youth Crime in cooperation with Federal agencies concerned with delinquency. The act provides for additional personnel for direct services and technical assistance to communities and training institutions, a responsibility delegated to the Children's Bureau and the Office of Education.

8. The best knowledge and information about child growth and development must be readily available to parents who are seeking it.

During the years 1957–1962, the Bureau strengthened its efforts in parent education. Its roster of publications for parents was increased and its consultation in parent education strengthened. The Bureau has made available consultative services on parent education to a broad range of agencies, both public and voluntary. Both child health and child welfare programs have stimulated the development of parent education groups, particularly for young unprepared parents. In 1961, the Bureau issued a

pictorial version of "Prenatal Care" entitled "When Your Baby Is On the Way," the first in a visual series of parent publications.

9. Children, because they cannot speak for themselves, need a spokesman.

On numerous occasions, the Children's Bureau has served as a spokesman for children by calling attention to situations affecting children adversely.

In 1960, the Bureau at the request of the Senate Appropriations Committee prepared a report on children of migrant families. Finding the plight of these families one of endless and, for far too many, hopeless struggle against insurmountable odds, the report urged, among other recommendations an expansion of child welfare, day care, and maternal and child health services to migrant families.

Unaccompanied Cuban refugee children provide a recent example of a special group requiring attention. The Children's Bureau has been consulting with the Florida State Department of Public Welfare and other States in planning for their care.

Since 1959 the Children's Bureau has been receiving an increasing number of reports about physical abuse of children by parents or others responsible for their care. Many of these came from hospitals where children were brought because of serious injuries inflicted by adults. In January the Bureau called together a group of 25 people—pediatricians, psychiatrists, social workers, public health nurses, and juvenile court judges—to consider what leadership the Bureau might offer. Once again the Bureau is alerting the public to a grave situation that demands combined attack on a complex problem.

10. Children's needs know no national boundaries.

The Children's Bureau has been continuing its efforts to develop and strengthen health and welfare services to children throughout the world, through its new research programs and participation in the work of UNICEF, with other official international agencies and our own governmental agencies that are responsible for the administration of programs of technical assistance.

In 1962, as we prepare for the Children's Bureau's 50th birthday, we stop to reflect upon the application of the Children's Bureau's tenets which have welded its programs into an effective instrument for improving the quality of life for children. Its interdisciplinary approach to all its activities—fact gathering, investigations and research, standard setting, consultation, administration of grant-in-aid programs—

A member of the Children's Bureau staff gathering information in Texas for a child labor survey during 1918.

is undertaken to one end: the optimum development of children and youth in their communities and in their families.

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A BROAD VIEW OF MATERNITY CARE

EDWIN M. GOLD, M.D.
Director of Obstetrics and Gynecology, Jewish Hospital of Brooklyn, New York City

IMPROVEMENTS in the health picture of this country in the past 50 years can perhaps be no more dramatically illustrated than with statistics on maternal and infant mortality. Deaths of women in childbirth dropped, for example, from 60.8 per 10,000 live births in 1915 (the earliest year for which such figures are obtainable) to 3.7 in 1959. Deaths of infants within the first year of life dropped from 99.9 per 1,000 live births in 1915 to 26.4 in 1959.[1] Behind these statistics is a story not only of unprecedented advance in medical knowledge but also of its application through the spread of services, a story in which the Children's Bureau has been intimately involved.

But within these statistics there is also another story—of the unevenness of progress between the less and more advantaged groups of the population, as revealed when the statistics are broken down between white and nonwhite groups of the population, and of a slowing down of progress in recent years, as shown particularly in the statistics on trends in perinatal mortality.

Moreover, the accumulation of knowledge and rapidity of medical advance in themselves have added tremendously to the complexity of maternal and infant care, while the problem of providing care has been further complicated by the steadily increasing demands of an expanding population.

No longer can the clinician in the field of maternal and infant health limit his concern to the perfection of diagnostic, therapeutic, and followup techniques in patient care. He must of necessity be concerned with personnel shortages, social upheavals, changes in the socioeconomic composition of the population he serves, gaps in services, rising costs, and above all challenges of pregnancy wastage and the handicapping conditions which are a continuum of reproductive loss.

Clinicians cannot cope with these problems alone. Future improvements in maternal and infant health must develop through close liaison between clinicians (obstetricians, pediatricians, and generalists), pathologists, social scientists, and public health specialists—epidemiologists, researchers, biostatisticians, health educators, and medical economists. They also will depend on a closer relationship of these physicians and scientists with nursing, nurse-midwifery, social service, and rehabilitation personnel.

Five and a half million births a year in the United States are expected by 1970 as against the present 4¼ million births in 1960. This look into the future is predicated upon the assumption that the birth rate of 25 per 1,000 population in this country will be maintained—and the chances are that it probably will. Serious consideration must therefore be given to the problems of providing good maternity care to all the childbearing women who will be a part of this population explosion. This will require that health supervision of all pregnant women be carried into the postpartum period, that it begin even before conception, and that it include attempts to prepare them and other members of the family for parenthood. Such continuity of care is appropriately called "perinatal care," and characterizes the modern concept of complete maternity care.

It is questionable that we shall have the necessary medical and nursing manpower to assure the total health supervision of all pregnant women in 1970. H. D. Kruse [2] has pointed out that to keep up with

the expected population growth, by maintaining the current physician-population ratio, would require increased enrollment in existing medical schools and the establishment of 20 to 24 new schools.

As of May 1959, there were 5,853 obstetricians certified by the American Board of Obstetrics and Gynecology. There are no data available on the types of physician performing deliveries, but obviously the number of certified obstetricians cannot possibly handle the current 4¼ million births. Probably most deliveries in the United States are performed by physicians in general practice. Yet all indications are that there will be a smaller proportion of generalists as well as certified obstetricians available in relation to the expanding population by 1970. How can we face up to this potential manpower deficit?

In New York City recently, the Obstetric Advisory Committee to the Commissioner of Health created a subcommittee on nurse-midwifery [3] which has recommended that nurse-midwife training programs be supported both locally and nationally. Envisaging thus a greater supply of nurse-midwives than is currently available, including apparently nurse-midwives trained for teaching, the committee has suggested that nurse-midwives could act as expert teachers of obstetrical nursing, could provide expert obstetrical nursing supervision in hospitals, and as assistants to practicing obstetricians could assume many of the responsibilities of antepartum care and patient observation during labor. In this latter role, according to the committee, the nurse-midwife could provide great service in enabling obstetricians and general practitioners to provide more and better obstetric care to more people in the years to come.

The report emphasized, however, that as obstetric assistant the nurse-midwife should always be under medical supervision and should never practice independently except in those remote areas of this country, and elsewhere in the world, where no doctors are available.

The development of nurse-midwifery training programs and the integration of nurse-midwife services into the total maternity care program of this country could be expected to do much to relieve the pressures of an anticipated shortage of physicians—if there were not a personnel shortage in the total supply of nurses, from which the nurse-midwives would presumably be recruited.

Unfortunately there are not enough nurses today to carry out all the other nursing functions required for the health care of the population as a whole, including the important function of maternity nursing. Therefore, it is doubtful whether sufficient nurse-midwives to relieve the pressure on obstetricians and general practitioners could be achieved in the near future.

Greater use of the team approach with the obstetrician serving as consultant and teacher to a clinical team composed of general practitioners, maternity nurses, nurse-midwives, and social workers and carrying direct responsibility for complicated cases, is being suggested by some concerned persons as a means of spreading the services of highly skilled personnel more equitably among the population. Another suggestion is for the more widespread use of group practice among obstetricians, helped out by a common team of auxiliary personnel. Group practice among general practitioners with an obstetrician available as a consultant has also been suggested. This would help doctors who have not specialized in obstetrics to deal more successfully with high risk cases. Refresher courses in obstetrics are of course a must for all professional persons who become involved in maternity care.

The possibility of using simpler facilities than the large general hospital for maternity patients and infants not requiring special care might also be considered—an approach which might not only be less expensive but more psychologically satisfactory to mothers than a setting geared to the care of the acutely ill.

Problems of the Cities

Economic and social problems connected with the population explosion also have a bearing on the prospects for good comprehensive maternity care. Such factors as the adequacy of family life, housing, education, preparation for family life, and family planning must be considered.

The great metropolises of this country have experienced dramatic changes in population composition in the past 10 years, which complicate the problem of seeing that all expectant mothers receive comprehensive maternity care. Many of our large cities have experienced an influx of low-income unskilled persons, many of them Negroes from rural areas of the South, while losing large segments of middle-income groups to the suburbs.

In 1950, 56 percent of all live white births and 51 percent of all nonwhite live births in the United States were to mothers living in metropolitan counties. In 1959 these proportions rose to 60 percent and 61 percent, respectively, reflecting the shifts of populations to urban areas. While in 1950, nonwhite

births represented 13 percent of all births in metropolitan counties, in 1959 they represented 16 percent.[1] In New York City this experience has been accompanied by a similar, but much greater influx of inmigrants from Puerto Rico—many of them also from rural areas and unskilled in the kind of work available in the city.

The swelling of the cities' populations of low-income, unskilled, relatively uneducated people, whose problems of securing adequate housing and jobs are complicated by racial discrimination, has been accompanied by a rise in social problems—dependency, juvenile delinquency, illegitimate pregnancies—and an interruption or reversal in some cities of the past 50 years' downward trends in maternal and perinatal mortality (deaths of infants in the first 28 days of life and fetal deaths occurring after the first 20 weeks of gestation). New York City, for example, has experienced a rise in maternal mortality from 6 per 10,000 live births in 1955 to 6.9 per 10,000 live births in 1960, and a 2-percent rise in perinatal mortality from 1950 to 1960.

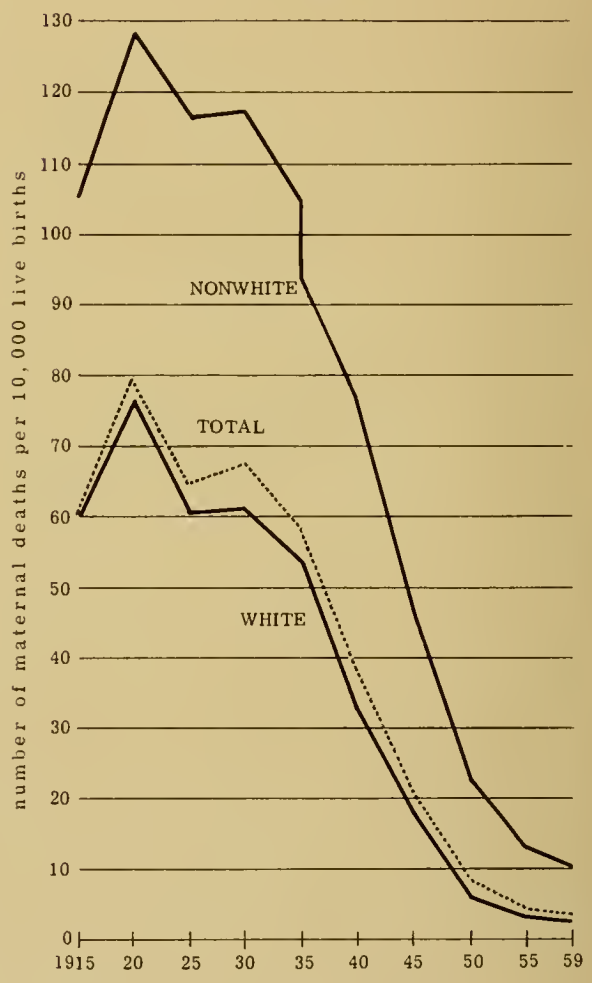
Maternal Mortality

While in the United States as a whole the maternal death rate reached an all-time low in 1959—3.7 per 10,000 live births, this was primarily due to the very great progress in reducing the mortality rate among white mothers, from 6.1 per 10,000 live births in 1950 to 2.6 in 1959. However, among nonwhite mothers the death rate in 1959 was about 4 times as great—10.2 per 10,000 live births, a rate that has not prevailed among white mothers since 1948. Progress in reducing the rate among nonwhite mothers is approximately a decade behind progress in reducing the rate among white mothers. The differences are much larger today than they were in 1915 when the rate for nonwhite (105.6) exceeded the rate for whites (60.1) by only 75 percent, as compared with today's 292 percent.[1]

The chief causes of maternal deaths in the United States today are toxemia (not connected with abortion), hemorrhage, and abortion (spontaneous and otherwise), each with a rate in 1959 of .7 per 10,000 live births. The rate for toxemia in which abortion is not a factor, represents a 76-percent drop from the 1949 rate of 2.9. The rates for hemorrhage and abortion (including abortion with toxemia and sepsis) represent less spectacular decreases—53 percent (from a rate of 1.5) and 36 percent (from a rate of 1.1), respectively. The 36-percent decrease in the rate of maternal deaths associated with abortion was, in fact, smaller than the decreases in the rates for all other causes.[1]

Obviously, current reliance on antibacterial therapy, blood transfusion, corticosteroid support, renal dialysis and even hysterectomy is insufficient to reduce the mortality from septic, endotoxic or bacterial shock secondary to abortion sepsis. Other means of prophylaxis against abortion deaths in addition to medical-surgical must be developed, including

U.S. TRENDS IN MATERNAL MORTALITY
1915–1959



source: National Vital Statistics Division

While the maternal mortality rate has dropped sharply among both white and nonwhite groups, in 1959 the rate in the nonwhite group was as high as for white mothers over a decade ago. Fluctuations before 1933 reflect expansion in the birth registration area which became complete that year.

programs for early, meaningful sex education, preparation for parenthood, family planning, and special efforts to reach newcomers in the cities with early prenatal care. Thus, the social scientist should be consulted by the obstetrician-gynecologist.

In addition, the cause of every maternal death must be carefully scrutinized in obstetrical staff conferences in hospitals, and there must be no relaxation of the activities of maternal mortality committees of county and State medical societies. Since 1929 such committees have been helping to reduce puerperal loss by pointing out avoidable factors in maternal death studies and suggesting improvement in teaching and practice which make for improved maternal care. They should be encouraged to expand their activities to promote standardized terminology and definitions in maternal death studies, develop uniform labor, delivery and puerperal records for use in hospitals, and contribute to community postgraduate physician education by setting up local institutes, seminars, and congresses devoted to maternal mortality control.

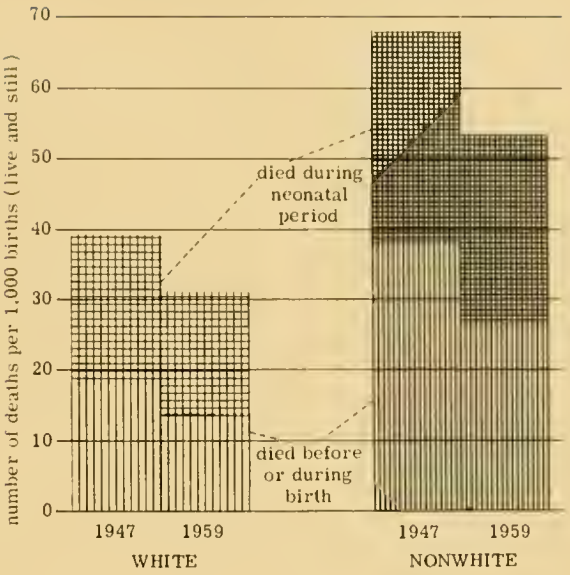
Perinatal Mortality

Perinatal mortality has notoriously failed to keep pace with the marked improvements in maternal and infant mortality over the years. During the 1950's national progress in reducing perinatal losses was slower than in the preceding decade. From 1952 to 1959 the perinatal mortality rate decreased from 37.4 per 1,000 total births (live and still) to 34.6, or a decrease of 2.8 deaths per 1,000. In contrast, during the years 1942–49, the rate was reduced from 50 to 40.4, a decrease of nearly 10 deaths per 1,000. Again we find a lag in progress in the nonwhite as compared with the white group. While the perinatal death rate among whites decreased from 1950 to 1959 by approximately 13 percent, the rate among nonwhites went down from 58.1 to 53.5—a drop of only 8 percent.

These significantly higher rates in the nonwhite group not unexpectedly go hand in hand with a higher incidence of premature births (or births of infants weighing 2,500 grams or less), since perinatal loss varies with weight grouping, being much higher in the premature than in the mature infant in all ethnic groups.

In 1959 the major causes of neonatal deaths were immaturity unqualified, postnatal asphyxia and atelectasis (collapse of lung), birth injuries, and congenital malformations, which together accounted for 74 percent of all neonatal deaths. They also produced an unknown quantity of neonatal morbidity resulting in such handicapping conditions as cerebral palsy, malformations not incompatible with life, epilepsy, mental retardation and behavior problems. Such problems represent a major public health challenge which can only be met by delineating etiologic factors.

CHANGES IN PERINATAL MORTALITY



source: National Vital Statistics Division

Perinatal mortality in this chart includes fetal deaths in pregnancies of 20 or more weeks and deaths of infants before 28 days of postnatal life. The "color" differences reflect differences in socioeconomic and other factors. The year 1947 is the first year for which such data is available by color.

In 1956, the National Institute of Neurological Diseases and Blindness embarked upon an intensive collaborative study on cerebral palsy and other neurological disorders of infancy and childhood, making grants to 15 major investigational centers throughout the country for a multidisciplined attack on these handicapping conditions. The purpose of the study is to correlate factors affecting the parents with the occurrence of abnormalities in their children.[4] Such factors as the course of pregnancy, labor and delivery, environmental influences including psychologic and emotional stress within the family, the family's socioeconomic state, and the mother's age, parity, medical and obstetric history and genetic background are under scrutiny in a sample group of births, as are any abnormalities appearing in the children at birth

or during infancy and early childhood. Much vital information on etiology is expected to accrue.

Available evidence suggests that anoxia of intra- or extra-uterine origin is probably the major underlying cause of perinatal mortality and morbidity. Of deaths in the first week of life in the United States in 1959, 26 percent were attributed to postnatal asphyxia and atelectasis.

Current research is supplying increasing knowledge as to the role anoxia plays in perinatal loss. Intrauterine anoxic stress at specific periods of the development of the fetus have been shown to produce fetal anomalies.[5] The state of the fetus in utero is being evaluated by estimations of gaseous exchange between fetal and maternal blood in the placenta,[6] as well as by electrocardiography[7] and phonocardiography.[8] Electrolyte metabolism of the infant at birth is also under scrutiny.[9] Means to prevent premature labor associated with an incompetent cervix have been reported.[10] Currently under study is the relation of the incidence of prematurity and perinatal mortality to asymptomatic bacteriuria (the presence of bacteria in the urine) during pregnancy.[11]

Prematurity

The high incidence of prematurity should be a cause of grave concern. While the proportion of white infants weighing less than 2,500 grams at birth dropped from 7.2 to 6.8 percent of live births from 1950 to 1959, the proportion of such premature infants among nonwhite births rose from 10.4 to 12.9. In some large cities, for example, New York, the rate of immaturity for the total population went up during the decade.

Prematurity incidence is intimately associated with the quality of prenatal care. One major criterion of good prenatal care is the time of its introduction, the earlier in pregnancy, the better. Yet the problem of patients receiving late or no prenatal care prior to delivery is still to be overcome. Baumgartner and associates,[12] reporting on prenatal care in New York City in 1951, showed that approximately 20 percent of all women whose pregnancies terminated in live births had late or no care, and that the highest incidence of such inadequacy was found in the lower socioeconomic population groups, in those patients delivered on the general ward service of the voluntary hospitals, and in the municipal hospitals.

The picture had not changed significantly by 1960. In the municipal hospitals, where the obstetric patients were of low income status, 42.5 percent had received late or no prenatal care. On the general ward services of the voluntary hospitals, where the patients are also of low economic status, 34.3 percent had had late or no prenatal care. In contrast, at the proprietary hospitals and on the private service of the voluntary hospitals, where the patients were of higher economic status, only 5.3 percent of the patients received late or no care prior to delivery.

Similar reports have come from other cities. For example, Oppenheimer[13] has reported that in 1956, 57, and 58, in Washington, D.C., 47 percent of the women delivered at D.C. General Hospital, the tax-supported hospital open only to low-income families, had had no prenatal care. In 1957 in this hospital 21.5 percent of the mothers with no prenatal care gave birth to premature babies as compared with 10.2 percent of those who had had prenatal care. In 1946, neonatal mortality among the hospital's deliveries which were not preceded by prenatal care was 41.6 per 1,000 live births as compared with 23.9 for the District's total population.

Thompson[14] has reported that at the Grady Hospital, a large municipal hospital in Atlanta, 23 percent of the patients who had come to the hospital for delivery during a study period had had no prenatal care, and only 11 percent had received prenatal care in the first trimester of pregnancy.

Socioeconomic Factors

Thompson has accumulated evidence indicating that the major factors involved in the rate differences in maternal mortality, perinatal mortality, and prematurity among the racial groups are socioeconomic in nature. He cites studies showing that:

1. A smaller proportion of Negro than white patients in both urban and rural areas are delivered in hospitals.

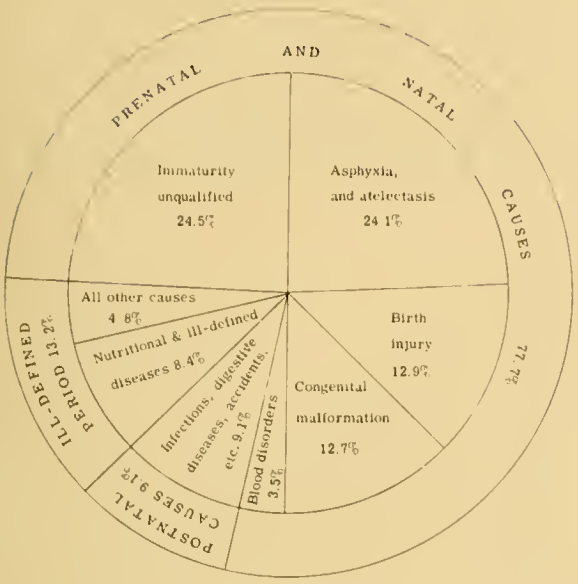
2. The incidence of toxemia has been found to be higher among patients in lower economic brackets.

3. Prematurity is more frequent among mothers who work outside the home; among those who have had inadequate prenatal care; among women who have poor diets; among women who become pregnant at an early or a late age or who are large multiparas, conditions found most frequently among low-income groups.[14]

How to reach more pregnant women of lower socioeconomic population groups earlier in pregnancy is a pressing and continuing problem. Community programs for early case findings, health ed-

CAUSES OF NEONATAL DEATH

United States 1959



source: National Vital Statistics Division

Over three out of four deaths of children under a month old are from causes arising either before or during birth.

ucation as to the benefits of early prenatal care and studies on motivation for prenatal care in these population groups, must be implemented on a broad scale.

It is also important to study procedures in the prenatal clinics in relation to their likelihood of encouraging or discouraging women to come for early and continuous prenatal care. How long do the patients have to wait to see a doctor? How comfortable are they made while they do wait? Has anyone inquired into the possibility of helping them make arrangements for the care of their other children while they attend the clinic, or are evening clinics held so that the woman may attend the clinic while her husband is available as a babysitter? Is the patient assigned a doctor of her own with whom she might build a doctor-patient relationship or is she likely to see a different doctor every time she attends? Is she encouraged to ask questions and express her fears?

Providing the public clinic patient with the kind of continuity of care and personal interest available to the private patients of obstetricians is not an easy problem for cities plagued by financial problems, staff shortages, and increasing caseloads. But experiments must be attempted if the task of assuring good maternity care for all mothers and infants is to be achieved. A few such experiments are underway.

For example, in New York City, attempts are being made through the cooperative efforts of the departments of health and hospitals to relieve the overcrowding in the clinics of the municipal hospitals by referring patients to the less crowded facilities of voluntary hospitals in the same health districts. The city has also begun to pay the doctors in the municipal hospital clinics, hoping in this way to alleviate personnel shortages.

The Philadelphia Department of Health has also been trying to relieve overcrowding in its municipal hospital clinics by contracting with voluntary hospitals to accept patients for care, and by establishing prenatal clinics in some of its neighborhood health centers.

In the District of Columbia, neighborhood prenatal clinics, closed for several years for budgetary reasons, were recently reopened when the health department produced figures showing a downward trend in prenatal care.

Perinatal mortality is higher in out-of-wedlock births in all ethnic groups. Pakter and associates [15] recently called attention to the increasing number of births to unmarried mothers. In New York City the incidence of out-of-wedlock births increased 16.7 percent from 3 percent of births in 1946 to 8 percent in 1959. Nationally they increased by 39 percent, from 3.6 percent of all live births in 1947 to 5 percent in 1958. The rates were highest among the less advantaged groups of the population.

The solution to this problem obviously is linked in a large part with the social and economic reforms sorely needed in large urban areas. All community resources including churches, schools, and welfare, housing, and health agencies, together with the mass media of communication and entertainment must be involved in efforts to strengthen family life.

Analyses Needed

In addition to the specific steps already suggested for reducing perinatal mortality and morbidity, broader concepts must be put into operation in an attack on the problem. One important approach is through perinatal mortality and morbidity studies. The Committee on Maternal and Child Care of the

Council on Medical Service of the American Medical Association is providing the lead in this direction.

In October of 1960, the committee created the American Medical Research Foundation [16] which sponsored a pilot project to study about 100,000 deliveries at about 100 hospitals in the United States, by computer methods. The goals are to encourage physicians and hospitals to maintain good records; to provide a technique that will be useful in investigating the problems of the perinatal period to encourage physicians to recognize the value of statistical studies; and to encourage local hospitals in self-analysis and evaluation of techniques, procedures, and results. The success of this pilot project may pave the way for uniform adoption of such control techniques by all hospitals.

In the meantime, the technique of self-analysis through the local perinatal mortality conference sponsored by hospitals, county medical societies, or health departments must be expanded. Such a conference brings together a multidisciplined group consisting of generalist, obstetrician, pediatrician, pathologist, biostatistician, public health physician, nurse, nutritionist, and other specialists to discuss errors of omission and commission in a given case, so as to prevent a recurrence in similar situations in the future.

The need also exists for more pathologists trained in perinatal pathology. Too few autopsies are being performed to provide physicians with sound anatomic information as to cause of death. The placenta is also being neglected. Strauss [17] recently pointed out the widespread lack of information on the nature and significance of structural alterations of the placenta and membranes, particularly with respect to their relation to perinatal loss and morbidity, and urged that placental examination become an integral part of perinatal study.

Limitations of space prevent discussion of other important problems requiring thought now and in the future. We are living in an era of nuclear as well as population explosions. What do we do about radiation fallout? How do we develop protection of our genetic future? What are safe limits of diagnostic radiation in maternal and child health perspectives? What about the emotional well-being of parents-to-be in such an era? Are we sufficiently concerned with psycho-emotional preparation for childbirth? Are we ready truly to plan our families and our futures?

All disciplines concerned with maternal and child health practices must share the responsibility to work out the right answers to such questions. Only then can we achieve the goal of maternity care spelled out by the World Health Organization: "to ensure that every expectant and nursing mother maintains good health, learns the art of child care, and bears healthy children."

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Providing all children with the benefits of modern medical knowledge requires . . .

A FRESH LOOK AT CHILD HEALTH

LEONA BAUMGARTNER, M.D.
Commissioner of Health, New York City

IT WOULD BE EASY to become complacent about the progress in child health in this country over the past 50 years if one could look only at the accomplishments and ignore the rather stubborn residue of problems. It would be easier if these remaining problems did not mean that thousands of children's lives were doomed to be cut off early or to be warped by crippling conditions, poor health, or emotional stress—many of them unnecessarily.

The accomplishments have indeed been spectacular, as the drop in overall childhood mortality during the period indicates. For example, deaths of children from ages 1 to 14 dropped from 514 per 100,000 in 1912 to 65.6 in 1959,[1] and deaths of infants dropped from 99.9 per 1,000 live births in 1915 to 26.4.[1]

Behind this progress have been four phenomena: the widespread adoption of sanitary measures by local governments; the medical breakthroughs which have accompanied the era's tremendous scientific advances; the growth of health services under a variety of auspices; and the ever rising standards of living.

Perhaps no developments have been more efficacious in saving children's lives than the public protection of water and milk supplies and the sanitary disposal of human waste. Following their introduction came the sharp reduction in deaths from that one-time number 1 baby killer, infectious diarrhea, and from such diseases as typhoid, and tuberculosis of the bone.

Probably the most effective of the medical advances have been the development of two types of sharp weapons against the communicable and infectious diseases: (1) the vaccines, which have nearly erased diphtheria and pertussis, and have reduced the incidence of poliomyelitis, and which may soon control measles; and (2) the antibiotic drugs which have cut so deeply into the toll from pneumonia, and from scarlet fever and strep throat and their sequelae, rheumatic fever, nephritis, and many forms of meningitis. Antibiotics have also contributed to the great reduction in the death toll from tuberculosis among children and young people, though another important factor in this reduction has undoubtedly been an improvement in living conditions even in crowded slum areas.

Other developments during the period which have saved children's lives or made their lives more bearable have been new forms of surgery for congenital defects, such as open-heart surgery; the isolation of nutritional elements and their use in food and drugs for the prevention and treatment of deficiency diseases such as rickets and pellagra; the introduction of drugs for the control of epileptic seizures and of hyperactivity in brain-damaged children; the designing of prostheses for child amputees suitable to children's developmental stages, and of electronic hearing aids that can be worn by young children; prophylaxis against gonorrheal conjunctivitis, a once frequent cause of blindness in the newborn; the prevention of congenital syphilis through premarital and prenatal blood testing and treatment; earlier and more effective rehabilitation for the crippled.

None of these weapons would have been as effective as they have been without the development of maternity services which have improved the chances of well babies being born; and of a host of other services—well-child conferences, crippled children's programs, school health services, clinics for the mentally retarded—which have seen to it that the new medical

A doctor examines a baby in a health survey undertaken in the rural areas of Mississippi by the Children's Bureau in 1918.

knowledge and skills have been put to use in behalf of children regardless of their walk of life, and at an earlier stage than if their complaints had waited until full-blown illness had descended. The part the Children's Bureau has played in its investigative, consultative, leadership, and grant-administering roles in working with State health departments and crippled children's agencies in the development of such services is described elsewhere. [See pages 43–51.]

Experience indicates that the provision of readily available services discovers many children who need care. For example, at least 1,519,760 children were served in the Federal-State aided child health conferences in 1959 as against 327,387 in 1937; and 340,000 children were served in the Federal-State crippled children's programs in 1959 as against 110,000 in 1937, when the services were just getting underway in a few areas.

These services have grown not only in numbers but also in types. For example, while the Federal-State crippled children's programs tended in the beginning to concentrate on the orthopedically handicapped, today children with such handicaps comprise only about 50 percent of those served, many States having extended their programs to include children with heart conditions, epilepsy, speech and hearing impairments, blindness, nephrosis, and other chronic diseases. Centers of services for the care of premature babies; for adolescents; and for children with more than one handicap have grown up too.

One of the greatest contributions of the Children's Bureau in the development of these services has been the spread of the concept of the team approach—the close working together case by case of an interdisciplinary professional team composed of pediatrician, appropriate medical specialists and therapists, nurse, nutritionist, and social worker—the kind of service needed to bring about speedier rehabilitation.

Clinical services to the mentally retarded have also received a tremendous boost in recent years, partly through Children's Bureau leadership and funds earmarked for the purpose by Congress, and partly through the efforts of State health departments and of organized parents' groups.

But all of this is not enough if the goal is to bring to all children the best that medicine has to offer.

Four major and interrelated problems confront those concerned with seeing that total health protection is provided for our Nation's children: (1) the stubborn medical problems which fail to reduce appreciably or which threaten to increase; (2) problems of the organization and distribution of services; (3) problems of professional practice; and (4) problems of the training of personnel.

Current Medical Problems

Most of today's major medical problems of children after infancy become apparent from a look at the major causes of death among children from 1 to 14. In 1959—the last year for which final figures were available—these problems were, in order of importance: accidents; malignant neoplasms (leukemia and other forms of cancer); congenital malformations; and, in spite of the antibiotics and comparatively new influenza vaccines, influenza and pneumonia.[1] While within this list there were important decreases in rates over the previous decade, the death rates from malignant neoplasms and from congenital malformations increased by 5 and 32 percent respectively.[1]

But causes of death tell nothing of the warping of children's lives by illness and handicapping. Accidents and an increasing incidence of congenital abnormalities play an important part here too. Added to these are all the chronic diseases and defects that may not kill but only pain—physically or emotionally or both: allergies; mental retardation; brain damage or impairments of limb, sight, or hearing

suffered at birth or as a result of acute illnesses; psychoneuroses; and venereal disease, once regarded as on the way out but now reportedly on the increase among teenagers.

Malignant neoplasms, congenital malformations, mental retardation, and allergies all are too little understood to be controllable to any great extent. Their causes may or may not be at least partially entangled with the increasing industrialization of our civilization. Analysis of the human cell and rapid advances in genetic knowledge are beginning to identify pieces of the puzzles and give promise for the future. For example, extra chromosomes or translocated chromosomes have been found in the cells of children with Mongolism, and metabolic defects have been discovered to be behind phenylketonuria and galactosemia, other causes of mental retardation.

Much research will have to take place before we can look forward to prevention or cure of many of the chronic conditions from which children suffer. The enthusiasm with which the President has recently supported additional research in certain aspects of child life is encouraging and will help fill a long felt need. Clearly research in child life and in child rearing has been a stepchild in the recent renaissance of health and medical care. Coordinated imagination and new approaches should bear fruit rapidly.

But much more is now known than is put into practice. We *can* prevent some accidents, birth injuries, tuberculosis, venereal disease, poliomyelitis, and many other illnesses which damage children physically and emotionally. We *can* alleviate their effects as well as many of the effects of other chronic conditions and congenital impairments. Such prevention demands quality, coverage, and coordination in health services, including those carried out by physicians in private practice as well as those offered under a variety of auspices. It requires a greater understanding on the part of the public and parents as to what can and needs to be done.

Better Use of What We Know

If we look at what we now know and then ask if all our children are benefiting by modern knowledge and skills, the answer is *no*. If we look at random samples of families, sick or poor, urban or rural, the lack of continuing and comprehensive health care of a high quality, the answer is also disappointing. Such care is essential to cope with the problems of chronic illness, congenital defects, and so on. Several factors are involved—all of them related—but some deserve our special attention.

These are:

1. **Cost.** Some people seem to believe that more dollars to pay for rising costs of hospital care, establishing new services, and so forth, will solve all problems. With our scarcity of nurses, physicians, and other health personnel this seems unlikely. Nor does money necessarily buy comprehensive care. That some families need help, particularly in caring for the young and the aged, is clear. The numbers of old and young are increasing and will continue to do so. This means a larger load for persons in their productive years. Financing health care is a problem, but far from the only one.

2. **Fragmentation and duplication of service.** Modern health care has grown more and more complicated as scientific knowledge has accumulated. It promises to continue to do so. The care of the chronically ill demands the teamwork of many kinds of professional workers. The parent is often left to shop for himself, or is referred from one doctor, one worker or agency to another—with far too little transfer of vital information and far too much duplication of diagnostic tests. Or if one looks at the community as the patient, there are too many hospital beds in one area, too few in another. Hospitals vie with each other to build, equip, and staff units to do cardiac surgery in areas where there is already enough of this highly specialized service to care for those who need it. There is resistance on the part of most health workers and community agencies to give up what they are doing. Planning takes time and we all have enough to do, so why bother. But with shortages of personnel and the rising population, communities must do better planning, hospitals and other agencies must coordinate services, and health workers need to do a better team job.

3. **Problems in rural and urban areas.** The problem of organization and distribution of services is in many ways different in urban and rural areas. In rural areas the problem is to attract adequate staff to these areas. The traditional rural problem of access to facilities has been greatly alleviated in the past 50 years by improved roads, by the now ubiquitous automobile, by the building of community hospitals—many with the aid of Federal funds under the Hill-Burton Act of 1946—and by the States' provision of traveling clinics, as in the crippled children's programs. Nevertheless, children in rural areas are greatly disadvantaged in regard to medical resources.

In some areas the problem is still severe. Physicians and nurses are scarce, and the specialists, which are so important to modern medical practice, are all but nonexistent. The problem in these areas is not so much coordination as something to coordinate.

In urban areas the complexities of getting the proper services to those who need them most when they need them most sometimes seem almost insuperable. Many of the country's greatest cities are today the starved cores of sprawling metropolitan areas, feeding numerous parasitic but politically independent communities in various stages of social organization or disorganization. They suffer from both a loss and a gain in population—a loss of the "haves" or revenue-producing groups to the suburbs and beyond—and a gain through immigration from rural and depressed areas of unskilled, nonrevenue producing "have nots," rich only in needs. Thus as their financial difficulties have increased, many of our large cities have found more and more families who cannot cope with their problems on their own.

Again money is not all that is needed. The multiplicity of voluntary and public agencies involved in health care is astounding; the aura of isolation that hangs over many of them is also astounding. The result is often a jungle of duplication and fragmentation, resulting in excellent care for some patients, partial care for others, and for still others little, except in emergencies. All kinds of services are interested in pieces of the child, but too often nobody sees the child whole. In the same hospital a child may be treated for an orthopedic condition, while his diabetic condition remains undiscovered until he becomes seriously ill, because no one thought to ask for a diabetes test. This can happen to rich or poor.

4. **The hard-to-reach problem.** Special studies have shown the extent to which a few "multiproblem" families use up public and private efforts in behalf of those who do not care entirely for themselves.[2] Many city health authorities worry about the people who fail to use available services despite their ready availability. Why, for instance, has polio immunization remained low in the crowded slums even when "polio buses" were put on the streets? Why are relatively few preschool children taken to neighborhood well-child conferences? Why do parents break their children's appointments? How many child health conferences reach out to find the preschool children who should be under their supervision? Or how many pediatric clinics follow through on broken appointments?

The answers lie in part with the need for health education, particularly among the newcomers to the city who know little about its services and who may have little understanding of the need for them. Somehow the passive, ignorant, or resistive elements of our population must be reached. The "how" is a problem that needs as serious research as does a new virus disease. The protection of our Nation's children cannot wait for a child's critical illness to rouse his parents to action.

Passivity, however, may not be more of a problem than discouragement. The clinic patient's lot is to wait. And how long can a mother wait with one child if she knows her other children are due home from school, or that the neighbor who is staying with the baby might have to leave before she gets home? How long can she keep a sick child in a noisy, stuffy waiting room if she cannot even find him sitting space? What can be expected of her if after all her arrangements and an afternoon of patient waiting, she is told that she has brought little Johnny to the wrong place or at the wrong time?

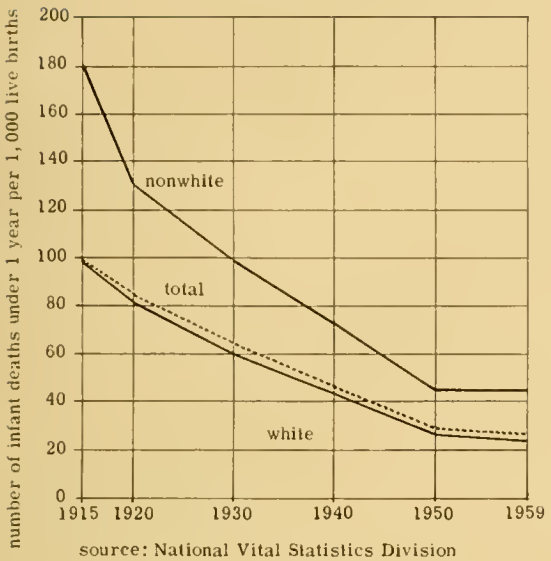
Closer coordination between welfare and health departments is one way of reaching that portion of the population known as indigent, or medically indigent, with health information and preventive services as well as with medical care. In New York City we are making some strides in integrating the provision of health and welfare services through the establishment of an interdepartmental health council, composed of the heads of the municipal departments of health, hospitals, welfare, and mental health, and the joint appointment by health and welfare of a medical director of medical care.

Under a system arranged by the council, district health officers from the department of health act as medical consultants to welfare centers. They visit nursing homes where clients of the welfare department are being cared for, set up referral systems to health department and other community services for pregnant women, preschool children, and infants. An extra dividend of this service is the development of an increased respect for health services by welfare department caseworkers and of welfare problems and services by health department personnel. Imaginative small projects to uncover and deal with special health problems of welfare clients are developing spontaneously. But there is still a hard core of families, plagued by many problems, who use the community services. Many of these are among the indigent and the medically indigent.

The New York City Department of Health is car-

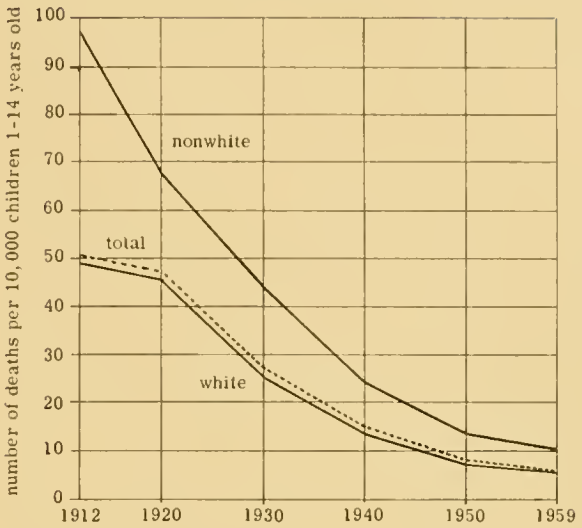
U.S. TRENDS IN MORTALITY AMONG INFANTS AND CHILDREN

Infant Mortality 1915–1959



source: National Vital Statistics Division

Childhood Mortality 1912–1959



source: National Vital Statistics Division

While death rates of infants and children have dropped sharply among both white and nonwhite groups of the population in the last half century, the rates in the nonwhite group have remained consistently higher, a fact which probably reflects the far higher proportion of low-income, and otherwise disadvantaged families in this segment of the population.

rying out another experiment to determine whether coordination of services really makes a difference in the quality and cost of care. In this 5-year program, 1,000 families who are on the public assistance rolls receive comprehensive, continuous, and coordinated medical care through a teaching hospital and a medical school. Other dependent families in the health district continue to receive care in the usual welfare department fashion of calling a physician from an available panel. Comparisons of the utilization rates, costs, and quality of care received by the two groups are being made.

5. **Problems of medical practice.** Problems of improving the quality and spread of health services to all children are intimately tied up with certain other problems in the practice of medicine today: (1) a more rapid integration of the increasing amount of scientific knowledge; (2) communication between the specialists and generalists as well as between the various professions and services involved in health care; (3) shortages—which promise to get worse before they get better—in all types of professional personnel, and especially in physicians; and (4) the efficient use of available personnel.

The modern trend toward specialization in the medical field can only increase with the ever expanding advance in medical knowledge and refinement of skills. No one physician today could keep up with all recent medical advances and learn all the new skills involved in practice and have time to apply these in caring for his patients. A major problem then becomes one of pooling knowledge so that the whole patient is kept in good repair.

One attempt to solve this problem found in many areas is the development of group practice—arrangements whereby several physicians practice together, sharing their special skills as well as the expense of high-priced diagnostic equipment and technical staff. Through such arrangements the patient's total medical care tends to be more continuous, and more comprehensive. His record is readily available to all. Frequent consultation among the physicians not only increases their knowledge about the individual patient, but about medical developments generally. Group practice may make it possible for doctors to

serve more patients than they could practicing alone and to have time for keeping abreast by attending brush-up courses and institutes.

But such arrangements rarely provide the complete team approach of generalist, specialist, nurse, social worker, nutritionist, and others conferring together on the total health problem of a patient—medical and environmental—and reaching a plan for his total treatment. This kind of overall look is obviously important for a growing child.

For this and other reasons, I strongly believe that hospitals too must in the future enlarge their roles as centers for community medical care, making available the specialized staff and equipment that all physicians need to supply comprehensive and continuing care of a high quality. But there must be a radical change in the operation and point of view of most hospitals before they can function in this way. Many hospitals are reaching out in this direction and are seeing themselves in a new role.

Hospitals are advancing in three other areas:

• *Progressive patient care.* In-patients should be encouraged to do what they safely can for themselves. Procedures allowing them to walk to meals, for example, can save a lot of money and personnel, since it is enormously expensive to feed a patient in bed. The modern pediatric service less and less resembles the old "sick baby" service.

• *Hospital routines.* These have tended to freeze into set ways and need to be thawed out with the use of the imagination. Why haven't hospitals experimented with disposable sheets and frozen meals and other labor-saving possibilities? Or with recent developments in information control? This last might revolutionize the whole problem of collection, storage, retrieval, and the use of medical information, thus saving uncountable clerical time as well as assuring that a child's clinic record gets into the hands of his in-hospital doctor when he enters the hospital.

The use of electronic equipment to report continuously and record automatically on a patient's condition could free nurses for more personal care. Variations of the kind of equipment which now reports on the condition of a man or a monkey in a rocket are being tried out. The trick will be not to let the machine take over and thus isolate the patient even more from the art of the nurse, the personal touch which means so much to recovery, but to free the nurse for more personal contact than she is now allowed.

• *Ambulatory and home care.* Many children would never have to become in-patients if they had early and appropriate attention in the clinic, or doctor's office.

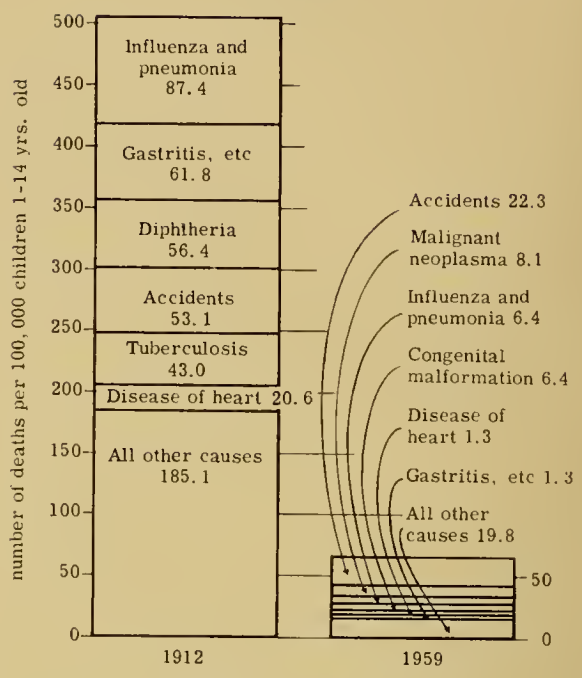
Many children would not have to enter the hospital or could leave it earlier if expert medical, nursing, and related services were provided for them at home. Some hospitals today are experimenting in this type of care for old people. It might just as appropriately be extended to children for whom separation from parents, especially when ill, can be a traumatic experience. Better ambulatory and home care can help cut costs of hospital care too.

Seeing the child "whole" requires a knowledge of his home life and environment and their relation to his health. But today, except in extreme emergencies, the modern physician sees patients only in his office or a hospital. Home visiting where it is done at all has become almost the exclusive province of the public health nurse. In too many cases it is not done at all even when it could prevent hospitalization.

Where there is no knowledge about the child's

CAUSES OF CHILDHOOD MORTALITY

1912–1959



source: National Vital Statistics Division

Changes in the chief causes of death among children have occurred with the drop in childhood mortality since 1912.

home life, the ability of his parents to carry out medical advice may be overlooked or misjudged as may environmental factors—emotional or physical—leading to the child's illness. How many tests, for example, might have to be given before diagnosing a child's illness as lead poisoning if nobody knows that the child lives in a dilapidated house "decorated" with old, flaking lead-based paint?

6. **Problems of training professional personnel.** An ever larger part of the pediatrician's or practitioner's job today is preventive—keeping the well child well. Another large part is devoted to the care and habilitation of congenitally impaired children. Both these tasks require seeing the child whole, and recognizing the factors, environmental and emotional as well as physical, which might lead to or aggravate illness. This is also true for others who work with children. Thus it has become important for the physician as well as for the nurse who cares for children to have a knowledge of the basic requirements of healthy child growth and development, of the social factors and intrafamily relationships which tend to enhance or impede such development, and of the resources available to relieve maladjustments.

One of the stickiest problems of medical education today—and a subject of considerable controversy—is how to provide medical students with this type of understanding without impinging on the time and energy required for acquiring a sufficiently sound basis of medical knowledge and techniques to treat the sick with confidence and skill. While some medical schools are introducing child-development concepts into their curricula and are providing students with opportunities to see patients as part of families in a social context, others are maintaining that the knowledge explosion in the medical field leaves no room for such "frills."

Understanding the various kinds of factors affecting child development can hardly be regarded as a frill in a pediatrician's armamentarium in view of the nature of pediatric practice today, though acquiring such an understanding may add to the amount of time needed to prepare for practice. In line with this point of view a number of medical schools are considering adding to the 2-year postgraduate training in pediatrics a third year fellowship or residency to focus on a study of growth and development, social adjustment, problems of adolescents, and problems of handicapped children, and to provide additional experience in child health supervision and family medical care.

A look at the adequacy of training must consider quantity as well as quality. The need for more personnel has been widely discussed and can be documented quickly, particularly in the child health field. Present predictions are that while the proportions of births may increase by 25 or 30 percent in 1970, the number of graduating physicians will increase only by about 18 percent, taking into account all present plans for medical school expansion.

The Priorities

It seems to me that the immediate challenge in health care as we look ahead is for better organization and planning in order to bring to all children what we now know we can do for them. That best in American medicine is very good indeed but many children are not receiving it. There is little chance that professional health personnel in these next few decades will increase proportionately to the growing population of youngsters. Therefore the problem of improved health care must depend on increased efficiency—better communication, better thinking, and better planning.

One of the most important things we as workers in the health field will have to think about is how to improve our communication: (1) with the families where the children live—so that mothers will not leave aspirin lying around where children can reach it, and *will* bring their children to be protected against polio; (2) with each other to assure continuity and quality of care; and (3) with the various community services—schools, social agencies, housing and school authorities, even landlords, so that no aspect of a child's life which might affect his health will be overlooked.

Our Nation's organizing ability is famous the world over. But we have not applied our best organization methods to the field of medical care. We need research and pilot projects aimed at increasing efficiency in the provision of health services. We also need pilot projects to raise community living standards, for these too are a part of the child health picture. In short, we need to apply the same thought and skill to providing all children with top quality health protection as has been applied in learning how to combat specific diseases. We will all be benefactors.

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[1] Source of figures: National Vital Statistics Division, Public Health Service, U.S. Department of Health, Education, and Welfare.

[2] Bradley Buell and Associates: Community planning for human services. Columbia University Press, New York. 1952.

SOCIAL SERVICES FOR CHILDREN AND YOUTH

LEONARD W. MAYO
Executive Director
Association for the Aid of Crippled Children

JOSEPH H. REID
Executive Director
Child Welfare League of America

DURING the past 50 years there have been earthshaking changes in society. In spite of this, the children being born in 1962 will have the same basic needs as those who came into the world in 1912. There is an urgency about children's needs, for they must be met as they arise.

In 1912 when the Federal Government first expressed interest in the prevention, alleviation, and correction of conditions adversely affecting children, through the creation of the Children's Bureau, the major problems were infant and maternal mortality, child labor and exploitation, and the loss of parents due to illness. Since then, however, medical advances and public health measures have reduced mortality of parents as well as children; a variety of public and voluntary social agencies have in many communities provided for a better network of protective services; child-labor restrictions in Federal and State laws have left only a few fragments of the child-labor problem; and the social security program, minimum wage laws, vocational rehabilitation opportunities, and measures to raise the general level of employment have helped to provide income security for the vast numbers of wage earners and their families.

In addition, technological advances, rapid industrialization, and gradual urbanization of a large portion of the country have changed the general atmosphere in which children are reared.

Today there are estimated to be nearly 65 million children and youth under 18 years of age in the United States as compared with approximately 35 million in 1912. While our children today live in a society where abundance is more evenly distributed, they live in a time of almost unprecedented general tension and unclear values which almost inevitably penetrate in some fashion into their homes. Most parents, however, manage to provide a sufficiently warm and stable atmosphere in the home to ward off the unsettling effects of these intrusions. Others do not or cannot. While few parents these days die while their children are young, more parents become separated or divorced or even fail to marry at all. Too often children in such families—as in others which are broken in spirit if not in fact—become the victims of emotional exploitation or neglect. Thus strengthening family life must remain the major goal of social services for children.

True, the amorphous problems of tensions and values are not the only ones affecting the well-being of children. Many of the old problems remain, though in smaller proportions. There are still children, families, and whole communities hardly touched by the Nation's affluence. Today nearly one-fourth of the Nation's children are living in families with incomes below the taxable level—i.e. *less* than $1,325 for a mother and child; *less* than $2,675 for a married couple with two children, and *less* than $4,000 for a family of six.

Thus, a quarter of our children are living at a dangerously low income level—dangerous since poverty is not only an unhappy state but is receptive soil for dependency, disease, and delinquency. Too often

these children are also disadvantaged by cultural bleakness in the home, by the inferior quality of education available in the communities in which they live, and by racial discrimination. Economic and educational programs must go hand in hand with the social services to give these children a better chance. Public assistance programs have an important part to play in keeping them at home with their families and in school. The role the ADC program has played in this regard is often overlooked.

But today, as in every other era of history, children from all walks of life face problems that threaten their wholesome development. Perhaps the most significant factor affecting family life has been the general replacement of the large interdependent family group by the small nuclear family—husband, wife, and children. This small family is much more vulnerable to internal stress and so more apt to need the social services of the community. An emotionally disturbed child, a mentally retarded child, a juvenile delinquent, or an unmarried mother is not necessarily the product of poverty. At every income level, too, there are parents who because of serious personal problems or conditions beyond their control cannot meet the needs of their children; hence, the continuing growth of services for children whose families are unable for any reason to meet their needs, either partially or completely. The goal of such child welfare services is to create the conditions and develop the opportunities that will help the child to realize his full capacities. Needless to say, the struggle to bring all services for children to this high level of attainment is a continuing one.

A new skill is acquired by these youngsters during their rest period in a community day care center in Elizabeth, N.J.

The Advisory Council on Child Welfare Services appointed by the Secretary of Health, Education, and Welfare in 1959 defined such services as:

> Those social services that supplement or substitute for parental care and supervision for the purpose of: protecting and promoting the welfare of children and youth; preventing neglect, abuse and exploitation; helping overcome problems that result in dependency, neglect, or delinquency; and, when needed, providing adequate care for children and youth away from their own homes, such care to be given in foster family homes, adoptive homes, child care institutions or other facilities.[1]

Thus, such services are broadly conceived as dealing with "youth" as well as children and having a preventive as well as a remedial function; and as being carried on under both voluntary and public auspices, in a pattern of complementary cooperation.

A Shift in Emphasis

In the early days of child welfare programs, because of lack of other resources, separation of the child from his family was apt to be necessary in instances of serious financial need, a parent's mental or physical illness, desertion, divorce, or other marital difficulties. Thus foster care, either in institutions or in a private home, became the basic child welfare service. However, the growth of public financial assistance and other modern social services, plus experience of many years of work with children in foster care, caused a shift in emphasis to work with children in their own homes and to services designed to prevent family breakdown. Foster care remains, and must remain, as a key child welfare service because there will always be some children whose homes will be disrupted either temporarily or permanently.

The fact is, however, that many of our foster care programs are substandard or inadequate particularly insofar as continuing work with the parents of children in foster care is concerned.

Child welfare workers know that once a home is broken and the children removed, the chances of a reunited family are apt to be slight. This was poignantly revealed in the study of foster care in nine cities made by the Child Welfare League of America 3 years ago. This study revealed that a child who is in foster care as long as 12 to 18 months is very likely to continue in foster care. One-third of the parents of the children studied had not even seen their children in a year. Over half the children were to some extent emotionally disturbed.[2]

These findings have given increasing impetus to

efforts not only to free children for adoption who have been practically if not technically abandoned, but also to provide the kind of concomitant services that can preserve child-parent ties or help parents to assume or resume major responsibility for the care of their children.

The report of the Advisory Council on Child Welfare recognized, as more and more agencies are beginning to recognize, that agencies must be prepared to reach out to some troubled parents who do not ask for help or perhaps do not even recognize their need for it. Here again the effort is on helping the parents build up their capacity for caring appropriately for their child. Such efforts are most often extended through "protective services" provided for children who are neglected or abused. In many instances such children are in families so overwhelmed by a multiplicity of handicaps—social, educational, or intellectual—that they do not easily respond to offers of help. Experience has shown, however, that when skilled casework is provided improvement frequently takes place in the parents' child-caring ability, though progress is usually slow.[2] When improvement does not take place, court action is called for in order to remove the neglected or abused child from his home for his own protection. In instances of immediate danger, the worker may have to call in the police.

Though certain private agencies pioneered for half a century in the provision of this type of service, such protection is being increasingly regarded as a public as well as a private function, and, in a number of States, public welfare agencies have assumed the responsibility. However, many communities today still do not have this important protective service at all.

Accent on Prevention

Today persons engaged in child welfare services are becoming increasingly concerned not only with finding ways of meeting the immediate needs of children who have problems but also of finding effective means of preventing these problems from occurring. The road to such prevention is regarded as the provision of the "good life" which by its very nature tends to exclude pathology. Prevention also occurs in situations where a pathological pattern has emerged but where skillful intervention blocks continuance and restores normal functioning. Applying this concept to child welfare means early casefinding of children who are in unwholesome situations or showing symptoms of disturbance. This means the child welfare agency must build a rapprochement with nursery schools, schools, pediatricians, public health nurses, public assistance workers, and others in a position to identify children and families with potential problems.

The increasing emphasis on serving the child in his home has tended to underscore the complementary nature of child welfare and family services, the one focusing on the protection and nurture of the child within context of the family and the other on total family functioning. Many of the processes and special skills required in these two types of services are necessarily different—as different as marital counseling and foster home selection, for example—but on the whole their basic methods of work and ultimate goals are the same. Any community program that tends to strengthen family life—be it family counseling, parent education, public assistance, vocational rehabilitation—helps to prevent problems which impair children's healthy development.

Two types of community services which are supplementary to the care parents themselves provide, homemaker services and day-care services, are far too inadequate in supply to accomplish their full possibilities in the prevention of family disintegration and child neglect.

Homemaker service, which may be under the auspices of a social or a health agency, provides trained, supervised homemakers to help with or assume temporarily the responsibilities of a mother who because of illness or other problems, cannot care for her children adequately; or, in a few places, to train immature, overwhelmed mothers in the arts of home management and child care. However, probably not more than 160 communities throughout the entire country offer homemaker services today, and where such services are offered, they are often too short of money or staff to meet the full need. For example, the one homemaker service in Washington, D.C., could handle only 60 of the 165 requests for service it received last December. Many children would be spared the traumatic experience of separation from their parents if this type of service were more generally available.

Day-care services provide part-time care of children in family homes, or more commonly, in child-care centers when parents are absent from home during the day, especially when the mother is working. The need for day-care services increases with the steady rise in the rate of employment among women. What the present inadequacy in such services can mean to children has been revealed in a 1-day sam-

ple survey made by the Bureau of the Census at the Children's Bureau's request in 1958. This indicated that some 400,000 children under 12 years of age were left on their own while their mothers were working.[3]

In response to a 1960 inquiry received from the Children's Bureau, 41 State welfare departments reported the need for additional day-care resources in industrial areas—especially for nonprofit, subsidized, low fee facilities; facilities available to Negro children, to the children of agricultural migrants, and to handicapped children; and family day-care homes for very young children.[4]

The problem of day care is not entirely one of availability of facilities. It is also one of standards, especially in relation to the many commercial preschool centers and informal day-care homes which have sprung up in industrial areas all over the country. Because children in day care need the same protection against fire, health hazards, and abuse as children in foster care, State licensing of all day-care facilities is a necessity. One-third of the State welfare departments have reported that their State's authority to license day-care facilities is now inadequate in coverage and in power of enforcement.[3]

Adoption

Adoption was not widely selected until the late 1930's as a method of providing care for children deprived of their own parents. While child welfare workers recognized the importance for every child of having a permanent home of his own, there was at one time so much fear about the possible effects of heredity on the child that it was very difficult to find adoptive homes for even the most attractive babies. As knowledge about the influences of environment in the development of children became more generally known, the idea of adoption became more acceptable, eventually growing into an overwhelming demand for healthy white infants.

As agencies gained experience in placing such babies for adoption, they began to see the possibilities of adoption for older children, for children with handicaps, and for those from racial minorities or of mixed racial background. Today many adoption agencies regard every child who is legally free from parental ties and who has no gross mental handicaps as available for adoption. While the number of children in each of these groups for whom adoptive homes have been found is proportionately small, their placement has demonstrated that there are couples willing to accept such children as their own and make them an integral part of their families.

The project in which the Child Welfare League of America and the Bureau of Indian Affairs, Department of Interior, are engaged, of bringing American Indian children in need of adoption from reservations in the West for placement through agencies in the East and Midwest, has shown the ability of families to absorb children from ethnic groups different from their own. This has been proven also by the intercountry adoption of oriental and other children.

In the last 10 years marked changes have taken place in the field of adoptions. Elaborate matching between child and prospective parents is no longer regarded as essential. Since child development studies have revealed the importance of early one-to-one child-mother relationships, today agencies with good standards attempt to place all children in their adoptive homes prior to 3 months of age, and many place children within a few days after birth. But the readiness of applicants to accept children who are different from themselves and to take the risk of receiving a child before his potential is fully established still transcends that of many placement agencies.

Applications from prospective adoptive parents have declined in recent years. The reasons for this are not wholly clear. Perhaps agencies discouraged applicants by overpublicizing the former disparity between numbers of children available for adoption and the number of applications—a disparity which actually existed only in regard to healthy white infants. Another reason may be that recent medical discoveries regarding causes of infertility and the corrective measures developed are enabling once childless couples to have their own children. Another factor may be related to the fact that since the war couples have been marrying and producing families at younger (and hence more fertile) ages than was usual during either the war or depression periods. Careful research to assess the cause of this trend is imperative for future planning.

Troubled Children

Institutional care was the earliest type of care in this country for children deprived of their parents. While foster family care began to be used in the mid-19th century, not until after the establishment of the Children's Bureau did the foster home movement begin to replace institutions as the preferred mode of care for most normal children away from their families. While there was a period of contro-

versy over the relative values of the two types of care, gradually it became apparent that while foster families are almost always preferable for young children, for older children the appropriate type of care varies with the child. Gradually, too, the institutions became the caretakers of those children who because of emotional difficulties could not remain at home and could not adjust to placement in family homes. Thus institutions for dependent children today are apt to contain a high proportion of children on whom devastating early experiences or longtime emotional deprivations have left deep emotional scars. By default they have fallen heir to a therapeutic as well as a caretaking function.

In recognition of this, many institutions have been not only providing skilled caseworkers and other professional personnel to help these children face and deal with their problems, but they have also been making efforts to give their child-caring personnel and even in some places their maintenance staff an understanding of the behavior of deprived children and their need for acceptance, love, and guidance. Institutions have also for the most part abandoned the old style congregate type of buildings in favor of smaller cottages where the children can live in a more normal manner and receive more individual attention. Most institutions for dependent children today send their children to local public schools and provide them with frequent opportunities to take part in community activities, but the high proportions of emotionally disturbed children in their charge have prompted some institutions to open their own special schools. Some institutions have developed into highly specialized services for seriously disturbed children. While no sharp line can be drawn between them and other good institutional facilities, these residential treatment centers are marked by their focus on the provision of intensive treatment for seriously disturbed children. The growth of this type of service has been slow, not only because of the lack of public understanding, but also because of high operative costs.

A homemaker from the Cook County (Illinois) Department of Public Welfare with one of the children of a family for whom she is temporarily serving as mother substitute, thus helping the family to remain together during a family emergency.

There is, however, a growing feeling that there are many children, especially among adolescents, for whom neither institutional care nor foster family care is appropriate. Consequently, many institutions and agencies have been experimenting with small group homes, for 4 to 8 children, which are completely integrated with the community. These homes, which are staffed by the agency, are usually located in a middle class residential neighborhood and the young people in them use the neighborhood's recreational, educational, and religious facilities. They provide children with a more normal life than large institutions without requiring the close relationships to parent substitutes often expected of children in foster families.

Institutions for juvenile delinquents have many of the problems of institutions for dependent children, aggravated by the extremes in behavior problems, by the unwieldy size of many institutions which must take all children committed to them by the courts, by their greater isolation from the community, and by the reluctance of many professional social workers to work with delinquents because of the difficulty of reaching them.

But the growing number of juvenile delinquents cannot be ignored. In 1960 about 443,000 children—or nearly 2 percent of all children between the ages of 10 and 17—appeared in juvenile courts for delinquency. This represented a 6 percent increase over the previous year although the child population in this age group increased by only 2 percent.[5]

In a sense these figures represent the failure of the community, a failure to provide whatever these young people needed in the way of service or opportunities to turn their energies to constructive rather than destructive channels. While little is known definitely about the causes of juvenile delinquency—

other than that they are manifold—there is much evidence to suggest that earlier attention to the problems of many a young delinquent might have prevented him from becoming one.

The formation of the President's Committee on Juvenile Delinquency and Congress's recent establishment of a 3-year program to provide funds and technical assistance for demonstration projects, personnel training, and coordination of community efforts in delinquency prevention and control are encouraging recognition of the many kinds of coordinated efforts required for combating this problem.

Too often the kind of care provided a child is determined more by the availabilty of resources than by the child's needs. This was vividly revealed a few years ago by a study made in New York State of 1,000 emotionally disturbed children referred for residential treatment. The study found that three-quarters of the children had been known to a community agency of some type before they were 9 years old, and "had received diagnostic, referral, and placement services and very little else in the way of treatment, such as casework, psychotherapy, or special educational arrangements." Because of the shortage of facilities, only 20 percent of the children could be accepted for residential treatment.[6]

Precise figures on the number of emotionally disturbed children are not available, but many child-caring agencies are alarmed at the proportions of children brought to them with serious emotional difficulties. Child guidance clinics all over the country have hopelessly long waiting lists, in spite of the great increases in these services since Federal funds for mental health activities became available under the National Mental Health Act of 1946. Some 250,000 children are treated each year in psychiatric clinics; and on any one day about 19,700 children with serious mental disorders are in our mental hospitals.[7]

A few agencies have been experimenting with the use of foster family homes for the care of mentally ill or seriously disturbed children who are receiving psychiatric treatment. The foster families with whom these children are placed are selected for their special warmth and ability to understand and deal with difficult children. Usually these families receive a fee for their services in addition to the payment for the child's board and room. Subsidized foster family homes are also being used in some places for the care of mentally retarded and physically handicapped children who cannot be with their own families.

During the past 15 years parents of mentally retarded and of emotionally disturbed children have become so concerned at the dearth and quality of educational opportunities, community facilities, and residential resources that they have organized themselves into local and State groups to work for better services. Their impact has been felt nationally. In some areas public child welfare agencies are working with such parent groups and with health and educational authorities to help parents deal with the problems of having a retarded child in the home and to enable the child to live as normal a life as possible.

While institutions for the retarded—especially the large State schools—are still plagued with problems of overcrowding and insufficient personnel, the trend among them is to focus on education, training, and rehabilitation rather than on custody, segregation, and control, and to look to return to the community of as many of their charges as possible.

The efforts of the National Association for Retarded Children, an association of parent groups, and the American Association on Mental Deficiency, a professional group, have promoted widespread interest in the mentally retarded. On October 17, 1961, President Kennedy announced the appointment of a Panel on Mental Retardation, charging it with devising a national program for an all-out attack on the problem. The panel and a small staff are now at work with the cooperation of several governmental departments and many voluntary groups. A report will be submitted to the President before December 1962.

Unmarried Mothers

The problem of unmarried motherhood like the problem of juvenile delinquency has received a great deal of public attention in recent years. And, similarly too, an apparent rise in incidence is behind the public's concern. Public Health Service figures indicate that in 1959 there were 221,000 illegitimate births in the United States, an increase of 12,000 over the previous year. Many of these births are among teenagers.

What the public does not always realize, however, is that this rise is not related exclusively to public assistance recipients. Only 13 percent of all illegitimate children are receiving aid to dependent children.[8] In a study of out-of-wedlock births in New York City, Pakter and associates found about an equal rate of repeated births out of wedlock among relief recipients and nonrecipients of the same socioeconomic groups.[9]

Because of our cultural and religious attitudes toward births out of wedlock, expectant unmarried mothers are usually in a high emotional state at a time when they must make grave decisions; therefore, they are frequently in need of casework or psychiatric services as well as medical care. Such services often help these women and girls to come to their own decisions about whether or not they will give up their babies for adoption or how they will plan their own future. Casework service also often helps the young woman to resolve those difficulties in her own personality that might have led her into her trouble, and is sometimes continued after the birth of the baby.

Many unmarried mothers—particularly among the low-income minority groups—do not receive such services, either because they do not know or do not understand the kind of help they might receive, or because lack of adoption opportunities in their communities for infants of their race provides them with no alternative but to keep their babies and, perhaps in some instances, dilutes the service agency's interest in them. In some communities ideas about real or imagined cultural differences have been behind the failure to extend such services to all who need them. What happens to the children born out of wedlock who are not adopted is one of the unknowns of social work and an area requiring a great deal of research.

Planning and Support

As the Report of the Advisory Council on Child Welfare Services emphasized, both public and voluntary efforts are needed to provide the services that the children of our country require. And they are needed to work not only side by side, but also hand in hand.

To be fully effective, all social services should fit into an overall pattern of community services and facilities. For a single agency to be effective there must be agreements among many agencies and practices established which are based on mutual understanding of the many services provided for families and children.

The boards and staffs of children's agencies, public and voluntary, must participate actively in community planning, have a sound working knowledge of children's needs and the different ways of meeting them that experience has shown to be successful. If a community does not offer the services needed by its children, laymen and professional people have a responsibility to see that they are developed.

The rights as well as the needs of children and parents are a major factor in planning; and this applies to all children in the community not merely those receiving agency care. Hence social agencies have a responsibility for promoting sound public policy, including legislation, for their own communities and States as well as for the Nation. This requires constant interpretation to the uninformed concerning child welfare and family needs and programs.

While many people maintain that we have reached the limit of what the public will stand for in expenditures for health and welfare, the question is whether we can afford not to support family and children's services more adequately. It is important for us to surpass other nations in our efforts to conquer space, but it is more important to conserve and strengthen our human resources—and here the welfare of all our children is of first priority.

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THE IMPACT OF THEORIES OF CHILD DEVELOPMENT

BETTYE M. CALDWELL
Research Associate

JULIUS B. RICHMOND, M.D.
Professor and Chairman

Department of Pediatrics, College of Medicine,
State University of New York at Syracuse

IT IS APPROPRIATE, on this 50th Anniversary of the Children's Bureau, to discuss the impact of child-development theories on child care in the United States, for no agency has had a greater influence on the gradual improvement of child health and the translation of child-development theory into practice than the Children's Bureau.

Direct improvements of the physical health of children are easier to assess than indirect benefits from educational programs. Yet in this area of indirect influence, the Children's Bureau has played a major role. The two pamphlets, "Prenatal Care" and "Infant Care" have over the years reached more American families than any comparable publications, thus serving as the major interpreters of child development theories. If one knew none of the direct research studies and none of the writings of the system makers, one could read successive editions of "Infant Care" and infer the prevailing theoretical approaches of each time period.

But even before the Children's Bureau, there were theories about the nature of the child and attempts to persuade parents to act toward their children in some particular way. Generally these theories were based on *a priori* assumptions rather than on any data and were theologically toned. An example is the doctrine of innate depravity which asserted that the child was inherently evil and that the main duty of parents and educators was to eradicate this depravity.

Probably each major theory which left any mark on the history of ideas had to be attuned to its era—a little bit, but not too far, ahead of its time. Thus intellectual prerevolutionary France was receptive to Rousseau's challenge of the doctrine of innate depravity with his assertion that the child is inherently good until corrupted by society. In postrevolutionary America, when rigid self-discipline and industry were required to subdue the frontier, theories which stressed obedience, discipline, and submission to adult authority found acceptance.

In every era there are two kinds of "experts" about child behavior—those who publish and those who do not. Every parent has his or her theory about how children develop. This theory may remain at the level of proverbs or cultural maxims ("Spare the rod and spoil the child"), may involve broad generalizations lacking behavioral referents ("Just give them love and security"), or may propose precise hypotheses about genetic influence on behavior or the relative efficacy of reward or punishment for inducing learning.

These implicit theories are important determinants of parental action and reaction. For example, a

"spare the rod" theory makes it unnecessary for the parent to make a fresh decision about how to handle a particular type of behavior each time it occurs; it also insulates the parent from guilt about behaving punitively toward his child.

Twentieth Century Theories

During the 20th century, three theoretical systems about child development have made major inroads into the personal learning theories of American parents: the behavioristic (or social learning); the maturational; and the psychoanalytic.

Social Learning Theories

While the work of several theorists could be cast into the framework of social learning theory, John B. Watson had the greatest influence in this direction. Watson's concept of infancy was essentially a Lockean *tabula rasa*—an amorphous bit of behavior potential to be shaped by the learning opportunities experienced by the infant. His psychological theories appeared at a time in the history of ideas when most complex types of emotional experience were attributed to the expression of instincts.

Convinced as he was that emotions were acquired through the learning process, Watson used naive subjects, infants, to test his hypotheses. He designed and executed a number of ingenious experiments which demonstrated that many fears could be acquired and subsequently eliminated through conditioning. From these experiments he concluded that most forms of complex behavior were the result of concatenations of reflexes and simple response systems associated through conditioning.

Such a view of the child places an awesome degree of power into the hands of parents and other "teachers." A completely malleable infant bespeaks an omnipotent training agent. Watson wasted no time in extrapolating from the laboratory to home and school and in communicating his ideas directly to parents. His widely read publications had considerable influence on recommendations made to parents about child care. The 1928 edition of "Infant Care," always the best statement of current professional ideas, relied heavily upon Watsonian suggestions about shaping behavior, such as developing habits of regularity, dependability, independence, and self-reliance.

Watson attempted to put to pasture many sacred cows of child development literature, including mother love and the importance of encouraging emotional dependency between parents and children. His language was too pungent to escape caricature. Witness this example:

> There is a sensible way of treating children. Treat them as though they were young adults. Let your behavior always be objective and kindly firm. Never hug and kiss them, never let them sit in your lap. If you must, kiss them once on the forehead when they say good night. Shake hands with them in the morning. Give them a pat on the head if they have made an extraordinarily good job of a difficult task. Try it out. In a week's time you will find how easy it is to be perfectly objective with your child and at the same time kindly. You will be utterly ashamed of the mawkish, sentimental way you have been handling it.[1]

Unfortunately publishers have no standard code for reporting whether an author wrote a particular passage with tongue in cheek. Therefore, an author must expect to be taken literally and to live with the implications of his words as written. In recent years Watson and his theories of conditioning have been felled by the impact of just such statements as the above. The reactions of his critics have ranged from vilification to mere ridicule, and feeling still runs high. Several modern theorists, however, notably Skinner,[2] Miller and Dollard,[3] and Rotter,[4] have significantly advanced social learning theory and have extended our knowledge about the limits of external manipulation and control of infant and child behavior.

Maturational Theory

This system is represented by the writings of Arnold Gesell.[5-8] A prolific and at times poetic writer, Gesell also recognized the journalistic principle that one picture is worth a thousand words and copiously illustrated his books with pictorial samples of child behavior. Although perhaps referred to more often for his methods of developmental diagnosis and cinema-analysis and for the norms of behavioral development which he and his students accumulated over the years, Gesell was nonetheless an important formulator of a theory of child behavior.

Gesell's theory of development is relatively simple yet, in some ways, more global than other more complex theories. The key concept is that of *maturation* or growth. It is a theory of intrinsic development, of an infant's maturation proceeding from both the human and the individual nature of the infant.

Implicit in the concept of maturation is self-regulation of growth. Gesell urged recognition of this principle in every aspect of development from the establishment of infant feeding schedules to the acquisition of moral values. Acceptance of the principle by parents calls for a certain considerateness, an

"alert liberalism," to use Gesell's phrase. Infants, as well as older children, are entitled to certain courtesies, to being regarded as "people." A passionate regard for the individual was, Gesell maintained, crucial to a truly democratic orientation to life.

A corollary of this stress on the importance of the individual is the concept of individual differences. Yet, paradoxically, it is here that Gesell seems to have been most generally misinterpreted and, indeed, almost to have courted misinterpretation. This stems from the organization of most of his books in terms of ages and stages of behavior. Indeed, the books' typography—the capitalization of each age period as though personified—conduces to such misinterpretation. For example:

> THREE is a kind of coming-of-age. . . . You can bargain with THREE and he can wait his turn . . . FOUR (and half past) tends to go out of bounds . . . FIVE is a SUPER-THREE with a socialized pride in clothes and accomplishments, a lover of praise.[6]

About this approach, Gesell and Ilg say:

> We regard the formal concept of chronological age and the functional concept of maturity level as indispensable both for practical common sense and for the science of child development. In the guidance of children it is absolutely necessary to consider the age values of behavior and the behavior values of age. The reader is warned, in advance, however, that *the age norms are not set up as standards and are designed only for orientation and interpretive purposes.* . . . The prevalence and significance of individual variations are recognized at every turn.[6]

Perhaps these occasional warnings do not carry enough weight to counterbalance the continued stress on ages and stages in development throughout childhood and adolescence.

With respect to the timing of the maximum impact of the three major theories we are discussing, Gesell followed Watson and preceded Freud. Nevertheless, many of Gesell's most popular publications came out during the period of popularization of psycholoanalytic thought. Gesell did not seem to be a man for polemics, however, and he seldom bothered to take notice of other points of view. His books deal largely with the presentation of his own material. He quotes other researchers only when their studies relate to his interests. In the four Gesell books reviewed for this article, there are only two references to Freud. Gesell was more concerned with developmental congruences than interpersonal conflicts, with eye-hand coordination and prehension than emotional cathexes. Even in the volume "Youth," [8] "sex" is indexed in terms of "differences" and not of preoccupations and problems.

Watson is quoted once in these four Gesell works, but anonymously as "a distinguished behaviorist" and the source of the quote is not in the reference list. However, in isolated articles, Gesell occasionally opposed certain points important in behavioristic doctrine, as he did when he suggested [9] that the conditioned reflex theory promised too much and threatened too much, and that maturation protected the infant from certain chance conditionings.

In reflecting on the impact of Gesell's work one must not overlook the influence of distribution.

Until the appearance of the amazing Spock volume,[10] Gesell's writings were probably more widely disseminated than any other full-length book on child development. Furthermore, Gesell, like Watson, was persuaded of the obligation to present child development material directly for parental consumption. Knowledge about infants and young children, he said, "must extend into the homes of the people; for the household is the 'cultural workshop' where human relationships are first formed."

Psychoanalytic Approach

The theoretical formulations of psychoanalysis and the body of empirical data collected to test the hypotheses have provided perhaps the most significant and pervasive influence on child-development theories and child-rearing practices in recent decades. By clinically reconstructing the life history of the adult or child through therapeutic efforts, psychoanalysts have developed theoretical formulations concerning the meaning of interaction of the infant or young child with his environment. It is understandable that, in a scientific era, a theory explaining the development in all its subtleties (unconscious and conscious) would capture widespread attention.

The complexities of psychoanalytic theory are difficult to distill into a few paragraphs. Unlike the maturation theory, psychoanalytic theory has undergone many revisions and is continuously modified. Classical (or Freudian) psychoanalysis and the neo-Freudian formulations differ in many respects.

Psychoanalysis is generally referred to as a biological theory of personality; yet the biological drives are manifested entirely in a social context. From the standpoint of the developing child, this context is mainly the family group. Unless basic drives (instincts) are gratified during early interactions with the parents—primarily the mother—the child moves forward from infancy with some degree of fixation at this earlier stage and somewhat impaired in adaptability. Or, if gratification at suc-

ceeding stages of development is insufficient, the child falls back on earlier patterns of behavior (regression) for gratification.

The concepts of fixation and regression are based on a sequence of stages in development. Thus personality development progresses from oral to anal stages in early life and then to a sequence of genital stages—oedipal, latent, adolescent, and mature. Experiences during each period are conceived of as affecting character traits of later life.

During the "oral period" in infancy, for example, it is thought the child develops feelings about accepting things and the mother's manner of giving them. Erikson [11] has postulated that from the totality of experiences in this period, the individual develops a basic sense of trust in people—or else a lack of trust which hampers his ensuing development. During the period of acquisition of bowel and bladder control when the child must integrate contradictory impulses of retention and elimination, traits related to orderliness, punctuality, and thrift are thought to develop.

The awareness of genital differences and feelings brings with it even more complex integrative tasks. Personality begins to take shape in more recognizable form, and characteristic modes of dealing with adaptive problems (mechanisms of defense) become evident. The relationship of the individual's later feelings and character traits to earlier experiences suggests that manipulation of these experiences in a "healthy" direction may favorably influence later development. This assumes agreement on a desirable mature model toward which to strive. Chronic failure of the parents to provide for the gratification of the basic drives is likely to result in permanent personality distortions remediable only through a kind of regrowth process via the therapeutic relationship.

These formulations have been theoretically enticing and have provided many hypotheses for investigation by workers in the field of child development as well as for child-care workers in various disciplines interested in the prevention of emotional disorders. Many psychoanalytic concepts have been embraced as guides to child rearing by parents concerned with raising "emotionally healthy" children. However, a review of the experimental literature [12] indicates that no specific relationships between early experiences and later development can be established at the present time.

There is growing recognition among psychoanalytic investigators that the application of knowledge gained from psychoanalysis in preventive efforts must be approached cautiously. The objective of psychoanalytic investigation as stated by Erikson [11] a decade ago remains valid:

> Psychoanalysis today is implementing the study of the ego, the core of the individual. It is shifting its emphasis from the concentrated study of the conditions which blunt and distort the individual ego to the study of the ego's roots in social organization. This we try to understand not in order to offer a rash cure to a rashly diagnosed society, but in order to first complete the blueprint of our method.

To pursue these objectives, psychoanalytic research workers are departing from the predominant use of reconstructive interview or play techniques to the greater use of direct observation of development (as indicated by the current interest in research in mother-infant interaction), experimental approaches (animal and human), and cross-cultural studies. Also, more intensive and objective studies of psychoanalytically oriented interviews are being developed.

Implications for Today

The fact that different theories can flourish contemporaneously validates Knapp's observation [13] that man is a "recalcitrant and reluctant experimental subject." Yet these theories of child development are not contradictory or mutually exclusive. All are concerned with learning, with the interaction of organism and environment. They all highlight different facets of behavior and use different conceptual systems. And, undoubtedly, they are all a little bit right.

From all of them one can infer that parents wield an awesome degree of power in shaping the lives of their children. Even maturational theory, with its emphasis upon the growth integrity of the young organism, its inherent potential for healthy development, implies that the parent can inhibit or distort this growth potential. With greater awareness of the implications of their caretaking activities, some parents have shown signs of what might be loosely termed a midcentury parental neurosis: an overdetermination to seek suggestions for child rearing as insurance of healthy development for their children.

Professional workers in the field of child care (pediatricians and other health workers, psychologists and child welfare workers) have not been immune to these pressures. They have sometimes advocated as universally desirable such programs as "natural childbirth," rooming-in of the newborn with the mother at the hospital, breast feeding, and per-

missive or self-regulating patterns of child care. To their credit, psychoanalysts have not been in the forefront of these movements. Rather, these movements have often represented misinterpretation or premature application of psychoanalytic principles. Recently they have been placed in a more appropriate perspective, as doctrinaire approaches to "prevention" have been given up in favor of the more traditionally eclectic orientation of child-care professions—except perhaps by social work which has remained heavily committed to psychoanalytic theory.

Guidance in child rearing will probably become increasingly professionalized in the United States in the years to come. The child-care professions, therefore, must face up to the challenge of providing services for parents even with incomplete knowledge. If these services are to be provided for families, adequate professional personnel must be made available. The specific professions to provide this personnel, the appropriate distribution, and the organization of services are issues with which we as a nation have not yet come to terms. The current ferment about the "new pediatrics" and concern with the directions in which this profession should move educationally and in practice suggests the need for planning constructively for all kinds of child-care services.

Since the launching of Sputnik in 1957, we have awakened to our responsibilities to fulfill our potentialities as a democratic nation. The resultant emphasis on academic achievement has the same overdetermined emphasis which other child-rearing formulae have had in previous years. While we must strive for full intellectual development of our children, this need not be at the expense of their social and emotional growth. If it is, we may inhibit the learning we seek to foster.

According to modern development theories a child's growth proceeds both from his individual and from his human nature.

Implications for Future Theories

What thoughts can now be projected about the child development theories of the future? Undoubtedly they will continue to be prevalent both at the scientific level and as part of each individual's general philosophy. The individual theories will change only as rapidly as cultural changes occur, and presumably those cultural changes will be at least in part a function of the rapidity of scientific change. However, we will make a few predictions about the characteristics of heuristic child development theories of the future:

1. Extrapolation from research data will not be so extreme.

The science of behavior has matured into a more conservative, slightly subdued stage. Professionals in the field have themselves matured somewhat. Also the interdisciplinary origin of many of the reasonably stable parts of child development knowledge is conducive to conservatism.

The young Watson, with little knowledge of genetics and its constitutional limitations upon adaptability of the organism, could assert that he could take any four healthy infants and make them whatever type of adult he wished. The somewhat provincial Freud, unaware of the nascent body of data from cultural anthropology, could assume that the memories and fantasies of individuals from a fairly narrow sociocultural context represented universal attributes. Today's theorists are no longer permitted the luxury of being uninformed about work in any area of knowledge which might limit the predictions from a given theoretical system. With greater availability of information which might make predictions hazardous, the theories themselves will become more cautious about specific predictions.

2. Future theories of child behavior will be concerned with a broader time spectrum.

The view of the child as a miniature adult is out-

moded. But in its place has come with too much finality a view of the child almost as an eternal child. The child *is* a future adult, as he is a future adolescent and a future senescent. The 6-month-old baby who experiences a certain type of mothering will presumably carry some residual of that experience with him at age 3 or 13. Since each type of later experience may modify the nature of the residual, such differences need to be fully explored. Useful child development theories of the future will be concerned with predictions which span wide segments of the developmental curve, not just one narrow section.

3. Future theories of child behavior will be related to broader aspects of social theory and philosophy.

A point already stressed in this paper is that each enduring or influential child development theory related to powerful currents of social history. Within the past few decades even the seemingly remote physical sciences have had to face such a relationship. There is now less talk about a separation of science from values. Certainly in the field of child development no such separation is possible. We rear children to fit into a particular culture, on the basic premise that the culture is somehow "good" or at least acceptable.

The past two decades have seen considerable sniping at Watson for the naiveté of his theories, with an occasional implication that he was heartless and cruel for denouncing mother love and the child-rearing practices of most parents. Such criticism fails to recognize that Watson was far more explicit than most theorists about the behavioral attributes he wished to foster. He concludes one of his books [1] with a formal apologia to critics who have taken him to task for having no "ideals" for bringing up children, commenting perceptively that different programs of care fit different civilizations. Then he describes briefly the kind of child he had in mind when making his child-rearing suggestions, the kind he considered best adapted to the changing America of the late twenties:

We have tried to sketch in the foregoing chapters a child as free as possible of sensitivities to people and one who, almost from birth, is relatively independent of the family situation . . . Above all, we have tried to create a problem-solving child. We believe that a problem-solving technique (which can be trained) plus boundless absorption in activity (which can also be trained) are behavioristic factors which have worked in many civilizations of the past and which, so far as we can judge, will work equally well in most types of civilizations that are likely to confront us in the future.[1]

Undoubtedly, many persons would not agree with Watson's goals, but it is to his credit that he attempted to relate his theory to the social milieu.

4. Future theories of child development will not attempt to answer (or predict) everything about child development for all time. They will modestly relate themselves to one sociocultural group—until something is proven to have universal relevance—and for a finite scientific era.

New discoveries can outmode existing theories overnight. For example, future research on behavioral genetics might drastically modify many of the assumptions underlying research on the effects of specific parent practices on child behavior. Any heuristic theory will be quick to incorporate new data, thus building a more stately theoretical structure. Victor Hugo's tribute to the power of an idea whose time has come might well apply in reverse here, for nothing is more effete than a theory that has outlived its time.

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Child labor has diminished but we now face a serious problem of . . .

YOUTH AND WORK: THE SECOND CHALLENGE

ELI E. COHEN
Executive Secretary

LOUISE KAPP
Public Information Associate

National Committee on Employment of Youth, National Child Labor Committee

"I AM PARTICULARLY DISTURBED over the serious plight of the nearly one million out-of-school and out-of-work youth," said President Kennedy last November in announcing the formation of a special committee on youth employment. Several months earlier at a Conference on Unemployed Out-of-School Youth in Urban Areas sponsored by the National Committee on Children and Youth, James B. Conant, president emeritus of Harvard University, had warned that the situation represented "social dynamite." [1] Secretary of Labor Arthur Goldberg had called it "the most dangerous social condition in America," and Secretary of Health, Education, and Welfare Abraham Ribicoff, "a terrible waste of our youth."

At first glance, such decrying of unemployment among youth might seem ironic to persons who can recall another dangerous social condition which existed in America 50 years ago, widespread child labor. In 1910 one out of every seven children 10 to 15 years of age (or a total of more than 1,600,000 children) was working.[2] The "serious plight" then was that, for 10 to 12 hours a day, children were toiling in sweatshops, mines, and mills. The "terrible waste" was that many were forced to give up school, play, and a normal childhood, for work and wages.

How, then, do we explain our current concern? First, we deplored the fact that children had to work; now, we cry there are not enough jobs for youth. Has that proverbial pendulum again swung too far? Many persons and organizations that once fought against the evils of child labor—including the National Child Labor Committee—have now turned much of their attention to jobless youth. In solving child-labor problems, have we created a serious problem of unemployed youth?

There are no easy answers to these questions. To understand clearly what has happened, we must take a look at basic economic and social changes since the turn of the century.

In 1900 the United States was a nation of expanding frontiers. The economy was growing rapidly, with an insatiable appetite for unskilled labor. Immigration was encouraged to get the hands needed for building bridges, forging steel, laying railroad ties, and digging ditches. Adult labor, though inexpensive, was in insufficient supply, and child labor was even cheaper. Many thousands of children, some as young as 6 and 7, worked under intolerable conditions. "Not a day passes but that some child is made a helpless cripple," Professor William O. Krohn reported then.[3]

Enlightened forces, however, rallied to combat the use of child labor. In 1904, a voluntary organization, the National Child Labor Committee, was created for the purpose. In 1912, the Federal Children's Bureau was established and almost immediately set to work to investigate and expose the conditions under which children worked. [See pages 43–51.] Labor unions, which had long condemned child labor, increased their opposition.

The battle was long and arduous. It included such

discouraging setbacks as the 1918 [4] and 1922 [5] Supreme Court decisions declaring Federal child-labor laws unconstitutional and the failure to obtain ratification of a proposed child-labor constitutional amendment. But as the years passed, an increasing number of States enacted laws to regulate child labor.

With the need for unskilled labor declining in the 1920's, barriers to unlimited migration were erected. The depression of the thirties, with its widespread unemployment, accelerated sentiment for ending child labor. In 1936, Congress enacted the Walsh-Healey Act, establishing minimum age standards for manufacture or supply of goods to the Federal Government; in 1937 the Sugar Act set a 14-year minimum age as a condition for benefit payments in the production of sugar beets and sugar cane. Finally, in 1938, Congress enacted the Fair Labor Standards Act, marking the beginning of the end of the widespread use of child laborers in the United States.

The Fair Labor Standards Act sets a basic 16-year minimum age for employment in interstate commerce or in the production of goods for such commerce; reduces this to 14 for certain nonfactory occupations outside school hours under regulated conditions; and raises it to 18 for occupations declared hazardous by the Secretary of Labor. It also sets a 16-year minimum age for employment in agriculture during school hours.

Since the passage of this act, except for the period of labor shortages during World War II, the employment of young children has become much less of a problem in nonagricultural work. Contributing to this decline, in addition to Federal and State legislation, have been the activities of citizens' groups, labor unions, and enlightened management, and changes in the economy's occupational structure that have reduced industry's need for unskilled youth. In fact, the increasing insistence by employers that newly hired employees have a high school education has meant that the minimum ages used in actual employment practices often exceed those set by the law.

Fifty years ago the average age for entering the labor market was around 14 years; today it is between 18 and 19. All but a very small minority of children under 16 years of age today are enrolled in school.

Agriculture—the one sector of the economy still having extensive need for unskilled labor at peak periods—has proportionately the highest degree of child labor. It is the one place where a grave child-labor problem still exists.

In recent years investigators from the U.S. Department of Labor have found an average of approximately 10,000 violations of the Federal child-labor laws per year. Agriculture accounted for more of these than any other industry. Most of the violations in nonagricultural work involved minors 16

With photographs such as this, taken in 1911 of breaker boys in the Pennsylvania coal mines, photographer Lewis W. Hine drew the attention of the public to the plight of children, who formed a considerable part of the labor force of the time.

and 17 years of age employed in violation of one or more of the hazardous occupations orders.

Children who work in agriculture are protected by Federal child-labor legislation only during school hours when the 16-year minimum age applies. They are exempt from the minimum set for most other occupations when school is not in session. Moreover, they are not protected by most State child-labor laws. Only 11 States expressly set a minimum age for children working in agriculture outside school hours. Six have a 14-year minimum; four a 12- or a 14-year minimum, depending on type of work or whether the work is on school days or in vacation periods; and in one State the minimum age is 10.

As a result, many small children can still work long hours in the fields without breaking the law. A large percentage of these are children of migratory farm workers. The strengthening of Federal and State laws is needed to give children working in agriculture the same child-labor protection as others.

New Problems

Important as such protection is, we now know it will not by any means put an end to employment problems of young people. Today's threats affect older youngsters—16 to 21—not the 6- to 12-year-olds we were concerned about when the Children's Bureau came into being. These threats involve opportunities to start work, not the necessity to stop it. Equally serious, they include: increased competition for jobs from adults, machines, and the growing numbers of other young people; and a drying up in industry of unskilled entry jobs and higher requirements than ever before for education and training. The result is heavier unemployment among out-of-school teenagers than for any other age group. This poses two baffling questions: How can unskilled, inexperienced youth be made employable in an automated economy? How can enough jobs be found for the vast numbers of job seeking youngsters?

Thanks to the jump in the birth rate after World War II, 26 million new young workers will enter the labor force during this decade, 40 percent more than during the 1950's. On a yearly basis this means we will have about 3 million new young workers each year by the late 1960's, as compared with 2 million a year now starting their careers. No one can predict how many of these young people will actually get jobs. Already nearly a million young people under 25 are out of school and out of work. Teenagers have a rate of unemployment two to three times higher than the national average.

Automation is making it possible to produce much more goods with fewer and fewer workers. Its impact is being felt everywhere—in factories, offices, and farms. In April 1961, 70 percent of all unemployed men and 30 percent of all unemployed women had most recently worked in blue-collar occupations, most of them as operatives. Altogether some 2,700,000 unskilled or semiskilled workers were out of work. Such workers are among the first to be laid off, the last to find new jobs.

Most of the programs being developed today for cushioning the impact of automation are understandably concerned with the security of those already on the job, according to A. J. Raskin, labor reporter and editorial writer for the *New York Times*. He points out that while retraining, severance pay, and transfer plans for workers who have invested 10 or 20 years in skills for which there is suddenly no market are obviously essential, they are no help to the youngster looking for his first job. "To the extent that our attention is riveted on help for the worker jolted out of a job," he says, "the harshest impact will fall on the workers who are never hired . . . They are automation's severest casualties." [6]

Inadequate education and training is another big obstacle for many of these youngsters. In terms of qualifying for work, a high school diploma today is about as meaningful as one from elementary school 25 years ago. Yet, according to the predictions, 7,500,000 of the expected surge of young job seekers in the 1960's will not have completed high school. Employers will be less likely to hire them than other applicants. Some will be considered unemployable. Many will be underemployed. Others will flounder from one blind alley job to another, feeling defeated.

Failure to make good in the job world coming on top of failure in school may well be the emotional last straw. For some young people it may even mark the turning point toward delinquency. The picture will continue to grow darker for young job seekers as increasing automation raises skill and education requirements for available jobs even higher and as the number of unskilled jobs continues to shrink.

The most seriously handicapped youngsters are members of minority groups. While Negroes make up only one-tenth of our labor force, they account for almost one-fifth of all unemployed. Often, they are denied access to apprenticeship, on-the-job and other training programs, prerequisite to becoming skilled craftsmen. The U.S. Department of Labor reported in March 1960 that there were only 347,000 male Negro workers among the total of 8,222,000

Learning vocational skills such as the use of business machines, as in this class in a Chicago public school, will overcome a big obstacle for youngsters seeking jobs in a labor market in which the demand for unskilled workers is constantly narrowing.

craftsmen, foremen, and kindred workers in the labor force in 1959. No wonder, then, that many Negro youth regard education and training as largely a waste of time. The experiences of many of their parents and friends have taught them that the better opportunities are not for them.

Employment problems are also acute for rural youth. It is expected that about 65 percent of youngsters living in rural areas (where opportunities are declining steadily) will have to move to cities to look for jobs, although they too are rarely prepared for the kinds of jobs that are available.

Few young people expect to face the prospect of joblessness. Unlike the young people raised during the great depression of the thirties, today's youth has grown up in a time of relative prosperity. On the average, the young person today has stayed in school longer than the youth of any previous generation. His childhood and adolescence—his period of psychological and economic dependence—has lasted longer. He has had little opportunity to experience economic independence or to learn at firsthand about the meaning and function of money.

A first job can be an important step toward adulthood, independence, responsibility, and recognition of individual worth. But finding oneself "surplus" right from the start in a dizzyingly complicated labor market can be deeply damaging. It can affect a youngster's whole future, his attitude toward work, toward himself, toward his family and friends, and even toward his country.

In the first part of this article we asked the frequently raised question of whether our solutions to the child-labor problem had helped create today's youth-employment crisis. Certainly this is not the case. The new demands of our economy are for higher levels of education and vocational training than ever before—not lower. Increasingly there is less and less place in the job market for the unskilled, uneducated, and untrained. Since to be employable today's young people need as much education as they can get, weakening child-labor regulations by permitting earlier withdrawal from school would only create more problems for them. The welfare of children and youth require now more than ever that these child-labor laws be kept, strengthened where there are loop-holes (as in agriculture), and modified where they are unrealistic. We should not hesitate to review the laws from time to time and to revise specific outdated features such as the provision in some laws which prevents minors under 16 from being in a room where *any* kind of processing takes place, and which has led to young people being banned from rooms where coffee is being made.

What Are the Answers?

Solutions to the youth-employment problem require an increase in available job opportunities and improvement of youth's employability. Here are some specific proposals:

1. *Develop job opportunities for inexperienced youth.* Wide-scale action by business and industry is urgent. However, it seems unlikely that private employment alone will absorb the total work force in the foreseeable future. We have no alternative then, but to turn to the public sector of the economy. One method might be through a Federal program to subsidize work and training projects in public and private agencies and create work camps similar to those of the Civilian Conservation Corps of the thirties.

2. *Improve and expand vocational guidance and counseling services.* Many youngsters have no idea of what they can or want to do. Having over 30,000 different occupations to choose from today they need special help in deciding what to prepare for. Although schools have increased their vocational guidance programs under the stimulus of the National Defense Education Act of 1958, there is still a severe shortage of counselors. More than half the vocational guidance counselors today are working in only

seven States, having only a third of the Nation's children. The ratio of students to counselors needs to be cut down sharply from the present rate of 700 students for every counselor. The ideal would be one for every 250 to 300 students.

3. *Increase and improve vocational training and work-education programs* with emphasis on reaching young people who are regarded as potential school dropouts. The promise of such efforts for keeping young people in school is indicated by a project in St. Louis, part of the Ford Foundation's Greater Cities School Improvement Program in which the St. Louis Board of Education has organized a work-study program for potential dropouts. The board reports it is finding a substantial difference in retention between the work group and a control group of similar students.[7] Cooperation of management and labor and positive community attitudes must be an integral part of such an effort.

4. *Increase on-the-job training and apprenticeship programs for all youth.* Most of the too few programs that now exist select their participants chiefly from high school graduates, thus leaving the school dropouts without training opportunity. Almost all bar school dropouts and Negroes.

5. *Arouse labor and management to take action against racial discrimination in hiring, upgrading, and firing.*

6. *Increase efforts to raise vocational sights of youngsters from low-economic areas.* New York's Higher Horizons Program is one of the better-known approaches. Established in 1956 at a junior high school, the program provides remedial education, careful counseling, and cultural enrichment in the form of museum tours and concerts. A similar project is offered in Washington, D.C., at the Theodore Roosevelt High School. The National Urban League sponsors career clubs in 20 cities as part of its talent identification program, "Tomorrow's Scientists and Technicians." The Phelps-Stokes Fund carries on a project to improve instruction for Negroes in Southern secondary schools. More of such projects are needed, especially for young people who live in city slums or in disadvantaged rural areas.

7. *Provide special help for school dropouts.* Perhaps the best known program of this nature is the Detroit Job Upgrading Program, sponsored by public schools and community agencies. This is a year-round service, providing job-centered courses, vocational counseling, subsidized work experience, placement in full-time employment, and followup services.

8. *Give expert help to rural youth coming into cities to find jobs.* Many young people from rural areas have not had the benefit of qualified teachers, non-agricultural vocational courses, or vocational counseling.

9. *Study future manpower needs.* One of the effects of automation is a growing uncertainty of just what skills the labor market will need in coming years. To avoid training youngsters for obsolete jobs, research and planning on national, State, and local levels are urgent.

10. *Work for faster economic growth.* Obviously a rapidly expanding economy would be the safest assurance that enough jobs will be available for all those entering the labor market.

The Challenge

We can be proud of the great progress made through the years in protecting children from oppression and exploitation. That challenge has almost been met, but now we have a second: to equip our youngsters to overcome increasingly grave obstacles to employment; to see that enough jobs are created so that the numbers of jobless persons in this country go down, not up; to insure that all young people have the opportunity to develop their potentials to the maximum. A nation that can send a man into outer space certainly has the ability and resources to solve the job problems of its youth.

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THE WORLD'S DEPRIVED CHILDREN

ADELAIDE SINCLAIR

Deputy Director of United Nations Children's Fund

ANNIVERSARIES are a time for stocktaking. The 50th anniversary of the founding of the Children's Bureau invites consideration not only of its interesting evolution and magnificent influence on child welfare in the United States and abroad; but also of the future facing the increasing child population in less fortunate countries around the world. The United Nations Children's Fund (UNICEF), which has recently celebrated its 50th anniversary, has as its main concern, the needs of children in countries only recently beginning to develop their resources and the techniques by which these needs can best be met.

The Children's Bureau and UNICEF have arrived from different starting points and by different routes at the same fundamental conclusion: that attention must be given to the needs of the "whole child." These interrelated needs are different at different ages. They vary from country to country. They extend into the fields of health, nutrition, social welfare, education, and vocational guidance and training. But, to prepare children for useful and satisfying lives, all must be met.

To be realistic, concern for children should start with an awareness of the quantitative as well as the qualitative problems. In 1961, the population of the world passed the 3 billion mark. By the year 2000, if present trends continue, it will reach 6 billion. The growth tends to be greatest in the countries with the least resources.

At times the problems created by this population explosion appear to be beyond solution. But their magnitude and the efforts necessary for their solution should be viewed against the enormous achievements of this century in medicine, in agriculture, in industrial production, in the mass media of communication. The possibilities in these areas are hardly exhausted. If their potential can be combined with the developing countries' tremendous determination to achieve higher standards, and is supplemented by intelligent international assistance, progress should be possible.

The problem of preparing a child for life is much more difficult in the developing countries where social changes that have taken hundreds of years to accomplish in European cultures are being compressed into one or two generations. Some of the pressures of this accelerating history on the countries' leaders are suggested by a statement of former Prime Minister Julius Nyerere of Tanganyika:

> Our policy is to make haste slowly, but it may be hard to sell this to the people. Freedom to many means immediate betterment, as if by magic. We are not magicians. But unless I can meet at least some of these aspirations, my support will wane and my head will roll just as surely as the tickbird follows the rhino.

Hunger and Disease

Adequate food and health protection represent the first priorities for a child's survival. For persons living in economically developed areas, where on the whole these needs are adequately met, considerable imagination may be required to appreciate the extent to which hunger and sickness are still the familiar companions of two-thirds of humanity, from early childhood on.

Dr. Banay Ranjan Sen, the Director-General of the Food and Agriculture Organization, recently estimated that between one-third and one-half of the 3

billion inhabitants of the world are either undernourished or malnourished. Since young children are the group most vulnerable to malnutrition and since three-quarters of the world's children live in countries where at best, only a very precarious balance between food supplies and nutritional requirements can be maintained, the proportion of children who are undernourished or malnourished must be very much higher.

Since World War II, agricultural production in the low-income countries has barely kept pace with the population increase. Obviously, a considerably better record must be achieved if the incidence of malnutrition in children is to be reduced appreciably. In most of these areas there is a shortage of milk and other animal protein foods so essential to child growth. This, however, is only part of the problem, for often, even when high-protein foods are available, local custom denies them to young children and sometimes to pregnant and nursing women also.

Production must therefore be supplemented by education. Next to protein deficiency, iron-deficiency anemia is probably the most widespread form of malnutrition among the children of the less-developed countries. Vitamin A deficiency contributes to blindness among children in parts of the Far and Middle East.

Other health hazards for children remain great in many parts of Asia, Africa, and Latin America.

Three-quarters of the 75 or 80 million births that take place in the less-developed countries every year are assisted by untrained persons or are unattended. Prenatal and postnatal care, while on the increase, are far from adequate Maternal mortality is 5 to 10 times as high in these countries as it is in the United States and Europe; and infant mortality, though falling remains high: in parts of Asia and Africa it still runs from 300 to 400 per thousand live births. Infantile diarrheas, dysenteries, and other diseases related to unhygienic conditions are widespread and are a principal cause of infant deaths.

In countries where high health standards have been achieved, mortality among children aged 1 through 4 years has declined dramatically in the last 50 years and now runs about 1 per thousand.[1] In the less-developed countries, mortality among children in this age group averages about 40 per thousand.[2] In part this is due to the prevalence of common intestinal and respiratory diseases and the communicable diseases of childhood, diseases sharply reduced in the developed countries through sanitation and immunization. Children in this age group are also susceptible to the various endemic diseases that are prevalent in many parts of the tropics and subtropics—malaria, yaws, bilharziasis, leprosy, and tuberculosis, the last a growing problem in large overcrowded cities. Malnutrition also plays a considerable role in mortality among preschool children.

Not all of the diseases that affect children are amenable to the mass-control techniques successfully used in many areas to combat malaria, yaws, and leprosy. The rest must be controlled through the slow process of building up medical services, improving the levels of home and community sanitation, and educating families in the basic principles of child health and nutrition. The big problem here is the shortage of the necessary personnel such as doctors, nurses, trained midwives, sanitary engineers, and teachers. In North America and Western Europe, the ratio of doctors to inhabitants ranges from about 1 to 7,000 to 1 to 900. In the U.S.S.R., there is a doctor for every 550 inhabitants. The contrast in the less-developed areas is extreme. In Brazil there are 2,500 inhabitants per physician, in India, 5,000, in the Cameroun, 30,000. The situation in rural areas is much worse than these figures suggest, since physicians and other highly trained persons remain in the cities. In Peru, for example, there are 13 physicians for every 10,000 persons in the capital, Lima; 4 for every 10,000 persons in the department of Arequipa in which Lima is located; but only one for every 10,000 persons in the rest of the country.

Not By Bread Alone

Children, of course, are not just little animals, and we do not fulfill our responsibilities to them merely by meeting their biological needs. A preliminary survey of the needs of the world's children that was prepared for the June 1961 meeting of the UNICEF Executive Board, confirmed the fact that the vast majority of children in developing countries receive very inadequate preparation for adult life. The child's overriding need, once his biological necessities have been satisfied, is *education* in the most literal sense, a "leading forth" into adult life. Paradoxically, the very countries where population pressure is most severe are the ones that are invariably plagued by a shortage of personnel to man the development programs they so desperately need. Contributing to this waste of human resources are inadequate schooling, poor environmental and social conditions, and the necessity for many children to go to work at an early age, without training, in dead-end jobs.

More and better schooling is widely recognized by

the governments of the less-developed countries as a *sine qua non* of economic and social progress. Therefore, a high priority has been assigned by many of these governments to the expansion of education, and indeed, substantial progress has been made in recent years. Even so, the unfulfilled educational needs of the children of the world's low-income countries are immense. In countries accounting for about two-thirds of the world's population, less than 60 percent of the children between the ages of 4 and 15 years attend school. The educational facilities that are available often leave much to be desired.

Population increase adds to the magnitude of the problem: for example, in the southern part of Asia where, according to a recent UNESCO estimate, 87 million children still lack elementary educational facilities, the school-age population is expected to increase by 130 million by 1980. In the high-income regions—Europe, North America, Oceania, and the U.S.S.R.—about 17.5 percent of the total population is enrolled in school; in the low-income regions—Africa, Asia, and Latin America—only 10.2 percent, and this despite the fact that children account for a higher proportion of their population. The discrepancy is particularly marked in secondary and higher education. In the high-income regions, secondary schools account for 28 percent of the total school enrollment and higher education for 5 percent; in the low-income countries secondary enrollment accounts for only 10 percent of the enrollment, and higher education for 1 percent.

Without a certain degree of basic education, the children of the less-developed countries will, as adults, be able to do little to improve their precarious living conditions. Yet a very large proportion of them do not have the opportunity to acquire the most fundamental knowledge and skills. There are too few teachers and too few school buildings. There are shortages in school books, other teaching aids, and school furniture. The quality of teaching is often very poor.

Too often the education available in the less-developed countries is poorly adapted to the child's psychology and environment. Such aspects of education as vocational training, health instruction, and civic consciousness are frequently overlooked. Not only the content of education but the attitudes traditionally associated with it often limit its effectiveness as preparation for life. Kusum Nair, in her books on development in India,[3] notes that in West Bengal, where the spread of literacy has been phenomenal in the last decade, education has acquired a social meaning that bears no relation to its content:

> Whoever gets educated today . . . acquires invariably the upper class prejudices and postures as well, the most outstanding of which . . . is a strict aversion to and disdain for manual work. . . . It is rare now to find a boy in the rural areas of Bengal who has been to school for 7 or 8 years actually working on the land. By and large . . . this applies to the whole country, and it is not because more paying avenues of employment are immediately available to anyone who goes to school. It is the "educated," in fact, who face currently the greatest pressure of unemployment throughout India.

One reason the problem of education is critical and difficult is that in the rapidly developing countries the child needs to acquire an orientation to society often quite different from that of his parents. As W. A. Lewis, principal of the University College of the West Indies, has observed: "an industrial system makes demands on human personality rather different from those made by farming on one's own." Habits of punctuality, precision, and personal responsibility as part of a team, must be developed. "Much thought," says Professor Lewis, "has been given to adapting school curricula to technical needs, but less thought has been given to how the schools might be used to help young people acquire the attitudes which industrial life requires."[4]

A Social Vacuum

The child's social environment plays as important a role as his actual schooling in preparing him for life. The far-reaching social changes that have been taking place in the developing countries often have the effect of leaving the child in a social vacuum, lacking the support of either the traditional or modern patterns of social existence. George Dulphy, chief of Community Development of the United Nations Economic Commission for Africa, has given a telling schematic description of tropical African society in such rapid transition,[5] which typifies, with certain modifications, what is taking place in other parts of the developing world.

The primitive cultures of tropical Africa, Dulphy observes had salient characteristics in common. The population was dispersed among small villages living by subsistence agriculture. Living standards were low and precarious. The family, village, and tribal community dominated every aspect of existence, but the individual obtained from this a measure of security and a guarantee of group support. Traditional institutions, perfectly adapted to a static environment and a static mentality, tended to disintegrate in the face of the far-reaching political and economic changes that were initiated by the coming

of the Europeans and that proceeded with gathering momentum as the spirit of nationalism developed and as independence was won. There was simply not time, even in the countries where the political changes were accomplished smoothly, for a new social framework to develop before the traditional one was completely outmoded. In many instances, something approaching social chaos has resulted.

An accelerating rate of urbanization appears to be one of the inevitable consequences of the economic and social trends of our era, and a basic social problem of our century is that of easing the transition between a rural and an urban way of life. In 1900 about 89 million persons, accounting at that time for 5.5 percent of the world's population, lived in cities of 100,000 or more. By 1950 their number had increased to 314 million, or 13.1 percent of the total world's population. Accelerating urbanization is most marked in the less-developed regions. In this same period the number of persons living in large urban centers increased from an estimated 1.4 million to 10.2 million in Africa and from 19 million to 106 million in Asia. In the city of Leopoldville alone, the population has risen from 70,000 or 80,000 to 400,000 in the past 12 years.

The rural migrant thrown into the anonymity of the urban melting pot must surmount formidable material and psychological obstacles quite on his own, and he may be all the more unprepared to do so if he has just left an environment where the distinction between group and individual responsibility was all but nonexistent. With only his unskilled labor to sell—for which the exchange value is extremely low—the new arrival is hard-pressed to obtain sufficient food for survival. Consequently, urbanization often has a disastrous effect on family life. Many men who migrate to the cities from villages leave their wives and children behind. Perhaps they plan to send for them the day they are comfortably established, but this day often fails to arrive.

When the new arrival does bring his family to the city with him, or more frequently to one of the mushrooming shanty towns on the edge of the city, the living conditions are apt to be more crowded and unhealthy than those of the village the family left behind. The mother usually finds it impossible to feed her children with the money her husband is able to bring in. She looks for work herself, and if unable to find legitimate employment, may drift into prostitution. The children may at a very early age be left to find food for themselves outside the home, sometimes by performing odd jobs for a few pennies for something to eat, sometimes by sharing the food of other children, often by begging or stealing. The child who is fortunate enough to go to school finds himself confused, torn between the precepts of his parents' ancestral culture and the new principles learned from his teachers and textbooks.

Psychologically, the child in the rural areas is usually far better off. The extended family system is frequently the heart of the rural community. Every child feels that he has many mothers, many brothers and sisters. To help control the excessive migration of persons from the countryside to the city, a way must be found to make the material conditions of life in the villages more tolerable. This must be done without destroying the basic family structure of the rural community or more will be lost socially than gained economically. The rural community development programs in India, Pakistan, and parts of Africa are designed to tackle this problem, but efforts on a much more extensive scale are needed almost everywhere in Asia, Africa, and Latin America.

In the expanding urban slums, social services of a more familiar type are needed. Their first aim must be to help preserve threatened family ties. Two special problems also need to be met: juvenile delinquency and child abandonment.

Juvenile delinquency is one of the growing prob-

Convalescing patients in a pediatrics training hospital in India. UNICEF aids the training by providing equipment, stipends, books, and grants for instructors' salaries.

lems that high-income and low-income countries share. The causes are complex, but among them are the breakdown of family ties in a slum environment and the shortage of jobs for adolescents. Children and adolescents have a tremendous amount of physical and psychological energy. In the absence of constructive channels, this energy often flows into socially undesirable ones. Vocational training and job placement services for young people unable for various reasons to continue their formal schooling are badly needed everywhere.

The problem of abandoned children assumes considerable importance in countries where the rate of illegitimate births is high, as in many parts of Latin America. There are estimated to be about 250,000 wholly abandoned children in Peru. Legitimate children may become abandoned because of the illness or death of their parents. The problem is primarily urban, for, in rural communities, relatives are likely to adopt the homeless child.

Investing in Human Resources

What can be done to meet these critical needs of the world's less fortunate children—the children of Asia, Africa, and Latin America? A great deal of money—national development capital, foreign aid, United Nations' aid—is going into economic development programs designed to increase production and income in the developing countries. Too often social development is sacrificed and children get short changed. History provides many examples of the consequences of ignoring the fact that the development of human resources is just as important as of natural resources.

We have made remarkable progress in this century in developing scientific techniques that, if fully applied throughout the world, could go far to eliminate hunger and sickness. Even agricultural production could be doubled or quadrupled to meet the needs of the increasing world population if modern agricultural techniques were extended to all the world. Improved education techniques and the potential of the mass media of communication make possible a significant attack on illiteracy. To reap the maximum benefits of these developments, however, broad and careful planning must analyze a country's needs and potential. Priorities must be established to determine the order and rate of development of all aspects of national life.

The United Nations is laying much stress on what it calls "preinvestment" activities, which include assistance for the training of national personnel who will be needed to ensure the success of national development plans. No apology is needed for efforts to ensure that the welfare of children is not overlooked. Education in all its aspects—primary, secondary, vocational, and professional—appears to be the key to developing the capacities of children in the developing world.

An excellent Nigerian report, "Investment in Education",[6] points out that a tremendous educational undertaking will be required to meet Nigeria's anticipated need for trained personnel. Suggesting that "the Nigerian people will have to forego other things they want so that every penny is invested in education," it adds: "Even this will not be enough. Countries outside Nigeria will have to be enlisted to help with men and money. Nigerian education must for a time become an international enterprise."

This conclusion might well be broadened to: The preparation of children for adulthood in the world's less-developed areas must for a time become an international enterprise.

In a recent television interview, Kenneth Galbraith, United States Ambassador to India, was asked what he thought was the most promising development in American aid to India. He replied that, in his opinion, it was the discovery that "investment in people, investment in human beings and their education and their cultural development . . . is in its own way as important as investment in dams or physical hardware."

There appears to be a growing realization among policy makers, both national and international, that investment in human resources can pay high dividends. This trend, particularly if it can be accelerated, provides one of the best grounds for optimism concerning prospects for the 800 million children now living in countries where hunger, disease, and semi-illiteracy are still the rule and for the additional millions who will follow them in the decades ahead.

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U.S. GOVERNMENT PRINTING OFFICE: 1962

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EXCEPTIONAL CHILDREN AND YOUTH: a chart book of special educational enrollments in public day schools of the United States. Romaine P. Mackie and Patricia P. Robbins. Department of Health, Education, and Welfare, Office of Education. 1961. 14 pp. 15 cents.

A summary report of special education programs for exceptional children based on data collected from 4,990 public school systems in February 1958, a more detailed report of which will appear later. Tables and graphs support the text which classifies these children by category of "exceptionality" and type of educational program in which enrolled.

LEGISLATIVE GUIDES FOR THE TERMINATION OF PARENTAL RIGHTS AND RESPONSIBILITIES AND THE ADOPTION OF CHILDREN. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. CB Publication No. 394. 1961. 61 pp. 30 cents.

A presentation of principles for legislation and suggested language for State laws providing judicial proceedings for termination of parental rights and for adoption. [For a more detailed review see CHILDREN, September–October 1961, page 191.]

JUVENILE COURT STATISTICS, 1960. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. CB Statistical Series No. 65. 1961. 18 pp. Single copies free.

According to statistics for 1960 derived from a national sample of 502 juvenile courts, the year 1960 continued the rising trend in juvenile delinquency cases for the 12th consecutive year. The percentage rise in cases involving girls—usually less than that for boys—was 10 percent over 1959, compared with 5 percent for boys. Another reversed pattern occurred in a 7 percent increase of delinquency cases in urban courts, handling two-thirds of all such cases, compared with 3 percent in the rural.

JUVENILE DELINQUENCY—FACTS, FACETS: prediction and selection of delinquents. David J. Bordua. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. No. 17. 1961. 29 pp. 15 cents.

In the course of dealing with the logical bases for prediction and selection of delinquents and with ways of evaluating instruments used for these purposes, this publication describes an attempt by the New York City Youth Board to validate a social prediction table, discusses the KD Proneness Scale and concludes with the point that society's decision-making procedures must be geared to the fact that delinquency causation and delinquency prevention take place over long periods, rather than at a single point in time.

THE LEBANON STORY. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. 1961. 12 pp. 15 cents.

The story of how a Tennessee community, faced with the social by-products of rapid industrialization, has adapted ideas from the 1960 White House Conference on Children and Youth to meet the problems affecting its children and youth.

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Page 87, UNICEF, Jean Speiser.

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MAY • JUNE 1962

children

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Child Welfare Around the World

Speech and Hearing Impairments

Preschool Autistic Children

Deterrents to Prenatal Care

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children ®

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MAY–JUNE 1962

LEARNING ABOUT SOUND can be a surprise and delight to children such as these, to whom sound does not come naturally. Because of its effect in depriving children of speech stimulation, deafness or a severe hearing impairment can seriously impede a child's total development unless training in communication is begun early in life.

The importance of differential diagnosis in the treatment of communicative disorders is discussed in the article beginning on page 98.

Since becoming Secretary General of the International Union for Child Welfare in 1947, Dan Q. R. Mulock Houwer has visited child welfare organizations in nearly 30 countries. Previously he had worked closely with the Union while director of Zandbergen, an agency in Amersfoort, the Netherlands, offering residential treatment and foster family care to emotionally disturbed children, and before that as director of the National Bureau for Child Welfare at The Hague. Except for 3 years spent in a concentration camp during World War II, Mr. Mulock Houwer has been directing children's services since 1926 when he first became headmaster of an approved school for maladjusted children.

Before coming to the Children's Bureau in 1959, Donald A. Harrington was for 2 years speech and hearing specialist for the Office of Education. With a doctorate from Louisiana State University, he has been a faculty member of the speech departments of the University of Florida, Auburn University, the University of Oklahoma, and Louisiana State University. He has also directed the speech and hearing clinics at Auburn University and at the University of Florida.

Before becoming executive director of the West End Creche, Margaret Lovatt worked as a social worker in Toronto with the department of public welfare, and with the Protestant Children's Homes, a voluntary child placement service.

Active in numerous community and civic affairs, Mrs. Randolph Guggenheimer has been president of the National Committee for the Day Care of Children since 1958 when it was the Intercity Committee for the Day Care of Children. She is also chairman of the board of the Day Care Council of New York and a board member of the Citizens Committee for Children. From 1954 to 1957, she was vice-president of the Child Welfare League of America, and from 1952 to 1958 was on the executive committee of the National Social Welfare Assembly.

Howard B. Monahan (left) has recently left the California health department to become social work consultant for the Contra Costa Rehabilitation Council, Martinez, Calif. He has also worked for public and voluntary agencies in Colorado and Missouri. Esther C. Spencer, (right) before going to her present job 9 years ago, worked in tuberculosis control for the U.S. Public Health Service. She is teaching a seminar in social work practice in public health at the University of California, Berkeley.

◀ *the authors*

Editor:
Kathryn Close

Associate Editor:
Eleonora Chatty

Differences in resources and cultures in various parts of the world call for flexible approaches in helping . . .

CHILDREN— A UNIVERSAL CONCERN

DAN Q. R. MULOCK HOUWER
Secretary General, International Union for Child Welfare, Geneva

ON THE OCCASION of the 50th anniversary of the U.S. Children's Bureau, an enormous amount of material concerning conditions of American children in the past and today makes it possible to follow the development of child welfare in the United States, decade by decade, State by State, from a point of view of action by public and voluntary organizations, backed up by statistics, results of studies, and so on. On this basis, plans can be laid for the future of national child welfare. In respect to international child welfare not so much information is available and what there is is less reliable, more dispersed, and not easily brought together under one common denominator.

Some people look with rose-colored, others with dark, glasses at what material is available. I personally think that we should try to evaluate it with a cold, objective eye and a warm heart, even though we are aware that we do not possess very reliable statistics and that the situations on the various continents, even in the various countries within these continents, are very different as far as social conditions, health, education, and welfare are concerned. We must also be conscious of the fact that we are living in an epoch in which political and social patterns are changing quickly. Our goal, nevertheless, is to find out how we can influence developments in the international field in the right way for the world's children and thus for the world's future.

A well-known slogan says "history repeats itself." Maybe this is partly true when we compare our own child welfare history with present situations in the developing countries, for instance, in regard to the effects of urbanization and industrialization. However, today we also see new developments which have a character all their own. We are confronted with situations, philosophies, programing, and techniques which are different from those we know in the industrially developed West—the United States, Canada, Australia, New Zealand, and northern and western Europe. These differences represent, from several points of view, a challenge to which we must find not only the right, but also the convincing and successful answer.

Out of the world population of nearly 3 billion people, 65 percent are living in underdeveloped areas, in countries with the world's highest birth rates, highest child death rates, and also the lowest average incomes. The average annual expenditure per person in the United States, the United Kingdom, Western Germany, Sweden, and France merely on alcohol and tobacco is more than the average income per person in countries such as South Korea, Pakistan,

Based on a talk given at the celebration of the Children's Bureau's 50th Anniversary, Washington, D.C., April 9, 1962. (See page 120.)

Crowded classrooms, such as this one in Egypt, are prevalent in the developing countries, where widespread enthusiasm for education is a part of the revolution of rising expectations.

the Congo, India, and Burma, to mention only a few examples.

In Western countries the average annual increase of population is 0.7 percent, while in underdeveloped areas, such as Central America, the Middle East, and Southeast Asia it is estimated to be 2 percent; and in South America, Turkey, and Malaya—3 percent. All countries have had considerable internal migration. Since 1900, the increase in urban population in Europe and the United States has been nearly 160 percent, whereas in Asia it has been estimated to be about 450 percent and in Africa 625 percent.

In the towns of the developed Western countries, there are usually opportunities for work for people who have migrated there and the increasing demands in the field of education and child welfare can more or less be met. The same can be said in regard to the Soviet Union. For the underdeveloped countries, however, in Asia, Africa, and Central America, the move to the cities means rising unemployment or substandard wages, the hideous sprawl of shanty towns, or no housing at all, an ever multiplying army of underfed families and children, and insufficient health, education, and child welfare facilities.

It is estimated that throughout the world at least 250 million people annually suffer clinical attacks of malaria and that about 2½ million of them die of the disease each year. Ten to 12 million people are stricken by leprosy, among whom a large proportion are children. While many developed countries have begun closing their tuberculosis sanatoriums for lack of patients, in underdeveloped countries tuberculosis kills approximately 5 million people per year. An estimated one-seventh of the world population, or 400 million people, suffer from trachoma, and where no adequate care is available, 10 million of them will become blind. More than 250 million people in the tropical areas are believed to be infected by filariasis, which produces elephantiasis. It is estimated that about 56 percent of the population in the underdeveloped countries are underfed and 20 percent are living on the borderline of starvation.

Since in these areas the child population constitutes 40 to 45 percent of the total population, such examples would seem to give a pretty gloomy picture of the situation of the world's children. But there are other brighter examples showing how situations improve. Japan, for example, has tackled her difficulties, which were aggravated by overpopulation and wartime devastation, with increasing success by improving agriculture, developing small and large industries, introducing a birth control program, and taking the lead among the pioneers in child welfare in the Far East. Another breathtaking development is to be found in Russia where in 1913 the infant mortality rate per 1,000 live births was 273; in 1940, 184; and today, 40.6. In 1917, the average expectation of life in Russia was the same as in India; in 1959, it reached 67 years—or twice as high. In India the infant mortality rate, which in 1922 was 550 per 1,000 live births, has been reduced to 127.

Today there is practically no tropical sickness which we cannot control thanks to the advances made in medical science. To give some striking examples: Ghana, through a medical program aided by WHO and UNICEF, expects to cure 42,000 cases out of 50,000 of leprosy within a very short time and to eradicate this disease in the near future. In Taiwan, a school health education program, in which children help children, has cured one million out of the 2 million school children of trachoma. In Indonesia, where there were 12 million sufferers from yaws, eradication of this disease can be foreseen within a few years.

The introduction of preventive methods, such as inoculations, clinical treatments, environmental sanitation programs, and destruction of disease carriers, has shown that it is not necessary for diseases like yaws, malaria, leprosy, trachoma, yellow fever, hookworm, and other infections to continue to enslave

the peoples of the underdeveloped areas as they have for centuries.

The main problem is to accelerate progress in acquiring the trained personnel and services needed. North America has one medical school for every 1.9 million people; Central America, Europe (including U.S.S.R.), and Oceania have one medical school for every 2.2 to 2.5 million people; Asia has one for every 8.3 million and Africa one for every 22.4 million. Oceania has one school of nursing for every 50,000 inhabitants; the United States, North and West Europe, one for every 150,000; India, one for every 2.2 million; Africa, one for every 5 million.

Not only can we reduce the high death rate in the underdeveloped countries, but we can also vanquish such other causes of misery as illiteracy and ignorance. Yet there is a new social problem which these countries must face—the "population explosion." Paradoxically, progress in the medical field, which has resulted in a decreasing death rate among children and an increasing average life span, has at the same time increased misery, since there has not been parallel economic progress. As a result there is not sufficient food; and the schools, though growing in number, cannot cope with the greater numbers of children. More teachers, school equipment, and vocational training, are urgently needed, as are more and more jobs.

In 1950, the situation regarding illiteracy was: North America, 3–4 percent; Europe (including the Soviet Union), 7–9 percent; Oceania, 10–11 percent; Central America, 40–42 percent; South America, 42–44 percent; Asia, 60–65 percent; Central Asia, 80–85 percent; Africa, 80–85 percent. Education, and more education, is the hearty cry in all the underdeveloped countries. In India, nearly half the children of school age now go to school, and in various urban areas of underdeveloped countries in West Africa, the percentage of children attending school has leaped up to 60–80 percent.

Rising Expectations

Many countries formerly under colonial rule have become independent since the Second World War and this process is continuing. But becoming free does not mean becoming free from hunger, disease, poverty, and ignorance, nor the ability to switch over quickly from colonial rule to a democratic system of government and living. Nevertheless, in the worldwide "revolution of rising expectations" people are claiming a higher level of living and adequate opportunities in labor, health, education, and welfare. Many stumbling blocks have to be removed, the biggest from a child welfare point of view is the economic one.

When establishing child welfare services, the economic structure of the country has to be taken into consideration, and these services must also be flexible. As approximatley 85 percent of the people in underdeveloped countries still live in rural areas, child welfare policy and programing cannot be identical with policy and programing in Western urbanized countries.

Essential to improved child welfare policy and programs in rural areas are such questions as how to obtain a better water supply, how to improve hygienic conditions, how to set up schools, how to improve nutrition by better cooking and better feeding habits, and how to teach mothers better child care and sound home economics, adjusted to their local situation. These and other needs may be met by community development projects, improved roads, mother and child health centers, low-cost houses, improved husbandry, and subsistence agriculture. Last but not least, it is essential to make village life more attractive in order to reduce migration. The drift to the towns in accelerating the breakdown of the traditional pattern of tribal and caste customs is undermining the natural social security of tribal and caste systems. Only in some cities is this loss made good by some sort of legally established social security system.

The child welfare problems in the towns are dominated by an ever increasing number of orphans, abandoned and neglected children, and juvenile delinquents. There are some institutions such as orphanages and homes for vagrant children or, in some countries, child welfare services patterned on those of the previously ruling powers, but inadequate in quantity and quality. The greatest need is prevention. At the moment, the number of children in institutions is estimated to be .02 per 1,000 to .08 per 1,000, about 40 million in all the underdeveloped countries of the world.

One of the main problems is the lack of trained personnel in all fields of child welfare. Even the developed countries need more social workers, but in relation to the shortage in underdeveloped areas, the West's need is microscopic. India, for example, with a population of 400 million, has fewer students in the schools of social work than Belgium and the Netherlands with 9 and 11 million, respectively. But in this regard, too, the picture is changing. There are schools for social work in Lebanon,

Ethiopia, Peru, Ghana, the Philippines, Turkey, Iran, and Sierra Leone.

I have in mind too the excellent work carried out by the Youth and Sport Commissariat in Morocco, in setting up educational programs for girls and women in rural areas and institutional care for juvenile delinquents; in Egypt, the multisocial service centers in rural areas, combining health, agriculture, and education; in the Ivory Coast, the small but dynamic social welfare centers located in towns; in Ghana, a very active mass education program; in Nigeria, an excellent social welfare scheme in Lagos; and in India, the increasing attention given to child welfare programs within the framework of the 5-year plans—in cooperation with the voluntary agency, the Indian Council for Child Welfare.

Different Approaches

In developed countries, especially in free democratic States in which legislation provides both for the freedom of the individual and the protection of the weak and underprivileged, we are no longer worried by hunger and disease. Our child welfare programs are family centered; the family is seen as the nuclear cell in society. Our main concern is how to strengthen family life, how to prevent the child from being placed outside his family, how to correct by care, reeducation, and specialized treatment. Instead of the army of orphans and half-orphans of the past, we have today a not inconsiderable army of children who are victims of lack of love, inadequate education, disharmonious family life, divorce of their parents, or insufficient care because both of their parents work. And we have an increasing number of juvenile delinquents.

In the Western developed countries, we work on the principle that there is a functional relationship between prevention of maladjustment and the care of the child who cannot stay at home for one or another reason. Our aim is to improve the quality and quantity of such preventive services as family social agencies, child guidance clinics, vocational guidance bureaus, leisure time organizations, special police brigades, probation services, and children's courts. More and more we try to specialize the care for children through casework, group work, individual and group therapy, training centers, residential treatment centers, aftercare, and followup.

Problems in the field of child welfare in underdeveloped areas do not have the same character. They are both simpler and more complex. They are simpler if you see them merely from the point of view of the necessity to improve nutrition, hygiene and medical care, to increase the number of mother and child health centers, crèches, kindergartens, playgrounds, schools, vocational training centers, institutions for orphans, abandoned and delinquent children, and the like. They are more complex in regard to approach.

The democratic approach, which in Western countries has a long history and in which all our child welfare principles are rooted, is in many of the underdeveloped countries blocked by the fact that democracy and Western philosophy are not compatible with the internal historical and political situation. The strongest representation of a democratic philosophy in child welfare in any underdeveloped country is to be found in India, but for many other underdeveloped countries, the collective approach has attraction. The tribal community cannot be compared with our small two-generation family, and our Western approach, methodology, and techniques are therefore not tailormade for this culture. The Western approach is based on the "I (child)— you (parent)" relationship, the tribal approach on the "I (child)—we (tribe)" relationship, and the collective approach on the "I (child)—we (community)" relationship. A midway approach is the "I (child)—you (child care worker)—we (community)" which you find in Israel in the kibbutzim.

What complicates the Western or democratic approach is the manifest or latent antagonistic attitude in many underdeveloped areas toward Western people and customs and, in general, toward the democratic way of life, a combination of a reaction against former colonial rule, and the effect of all kinds of propaganda associated with the color bar, capitalism, imperialism, colonialism, and so on. If social workers fail to take such reactions into account, they remain blind to reality.

It is impossible to indicate a uniform child welfare approach, policy, and programing for the developing countries as there are so many different kinds of needs in the different parts of Africa, Asia, and South America. We are just beginning to recognize such differences and the various approaches indicated for adjusting modern knowledge, techniques, and skills to certain conceptions of community life.

Directions in the West

Affluent countries will certainly concentrate their attention more and more on their specific child welfare problems of which juvenile delinquency and gang behavior are the most widely known but do not,

in fact, constitute Problem Number One. Rather, Problem Number One is how to create a sound community spirit and life, and better training for citizenship. For curing our maladjusted and asocial youngsters, specialization is required. We shall always need child guidance clinics, treatment centers, and so on, but these do not eradicate maladjustment, juvenile delinquency, and gangsterism, just as malaria is not eradicated by excellent hospital care alone.

In order to give better services, two lines of development can be foreseen. The first is to invest more money in the services for preventive work and special care, especially in relation to family, school, job, leisure-time activities for youth, and the mass media of communication which have such a strong influence on our children and youth. In respect to these areas, material from the 1960 White House Conference on Children and Youth gives a rich source of suggestions as to what ought to be done.

In the Western developed countries, the functional relation between preventive work (care for the child at home) and child welfare services for the child who cannot stay in his own home (foster care and institutional care) will change increasingly, as the old formula of congregate institutions for deprived, maladjusted, or delinquent children changes in the direction of the cottage system. In countries where there is more differentiation in child welfare and where there is a better system of internal and external classification of institutions, the functional relation existing between foster care and institutional care will change too. One promising movement for preventive work may be found in what is called in Germany the "open door" homes—a very flexible, social pedagogical action for meeting, in a more constructive way, the youth on the street.

Another promising approach toward prevention of delinquency is to be found in the Dutch Ministry of Education's system of education and resocialization in short-term camps. These camps, which are only attended by youngsters who want to and are based on youth movement principles, are characterized by an excellent corrective, individualized school program and a way of living which trains for citizenship.

Other sunrays can be seen in the enormous amount of progress in reducing institutionalization of mildly and moderately mentally retarded children and young people. Thanks to improved and more adequate education and training programs, the majority of these youngsters not only can stay at home but can even find their place in the normal labor market. The more seriously handicapped can, for the most part, be maintained by "protected" workshops, clubs for their free time, and social pedagogical services to help them and assist their parents. It can be foreseen that organizations of parents of mentally retarded children will become stronger and stronger and will fight for these opportunities as they have done so successfully in the United States.

Another category of children for whom preventive services, in the form of day-care homes and day-care treatment centers, will be strengthened is that of the maladjusted children who cannot be satisfactorily helped by child guidance clinics, but for whom placement in a training school or residential treatment center is not desirable. In the last 15 years, various training schools and residential centers in developed countries of the West have been influenced by the work of such Americans as Bruno Bettelheim, Fritz Redl, Herschel Alt, Ernst Papanek, Gisela Konopka, Suzanne Schulze, and others, but it can be foreseen that a trend differing from the American conception will accelerate development based less on social work principles such as casework and group work, though advantage will be taken of these work techniques, and more on the psycho-

These two Peruvian brothers, who earn their living as water bearers in a Lima slum, illustrate the kind of problems which face child welfare efforts in many Latin American countries.

pedagogical and social pedagogical approach. One of the most beautiful realizations of this conception is the training center for specialized educators (psycho-pedagogues) in Montreal.

The total picture of institutional care shows an increasing weakening of the disciplinary (authoritarian) system, a decline of the progressive (advancing by degrees) system, and an increasing trend in the direction of the sociopedagogical (emphasis on the group and on collectivity), psycho-individual, and eclectic systems.

Foster family care will increase in European low-income countries as the standard of living rises, but it will decrease in economically developed countries because the increased affluence and problems of raising families in modern high-rise housing tend to decrease the availability of foster boarding homes.

Nevertheless, the trend toward finding a solution for maladjusted children in specialized foster family care will increase although it will remain limited and will mainly be used for the children and youngsters who for one or another reason are unsuited or less suited to residential care. One of the inspiring projects in this field is that of Prof. Hart de Ruyter at Groningen in the Netherlands. In regard to the criteria of placement, ideas are changing, particularly for this group of children. Ideas are less bound to casework principles than to the thought that for the key to each child's development, the right lock must be found.

It can be foreseen, however, that what will be most emphasized is the "link institution" between institutional care and foster care, the development of the group home, especially where there are special educational and treatment facilities in the community.

I believe that a second challenge will demand serious attention, and that is the problem posed by changing values in our Western world and the necessity for us, as adults, to review our own attitude, particularly in the fields of education and child welfare. We call the family one of the cornerstones of individual and social education, and, if there is any trouble with our youngsters, and with our adults too, we blame it mostly on their lack of love and security especially in the first years of life. While recognizing the value of this point of view, we surely should look more at the influence on total development of other periods of life and in this connection realize our failure to replace with a strong and inspiring value image what has today become a kind of "value vacuum."

If we do not find a solution for this, then our philosophy and democracy are at stake, for we are on the downward path of the hill of freedom when we claim too many rights without being sufficiently concerned about duties and obligations. No child welfare program can function adequately or develop into successful individual and social preventive work, supplemented by specialized care, if democracy is misused as a garden where the beautiful flowers of freedom can be picked without bothering about the responsibilities involved in keeping the soil of freedom and well-being fertile.

The Developing Countries

In the developing countries, the main fight will be in the economic field in order to improve agriculture and industry and raise the standard of living. Increasing attention will also be given to child welfare community development projects.

There will be a larger number of requests for projects to be assisted by the United Nations and its specialized agencies, such as the United Nations Bureau of Social Affairs, WHO, UNICEF, FAO, ILO, and UNESCO. One of the more important activities in child welfare is UNICEF's recently established program of assistance to social services for children.[1] More help is expected from nongovernmental international organizations, not only through material aid, but also in training at various levels, in cooperation with the United Nations specialized agencies, local governments, and voluntary groups. The training of top people is, however, hindered by the present small number of candidates with high school education, so that the most help will have to be given to training at the lower level.

Research will have to be extended to find out the best way of adjusting modern techniques to the lower income areas, to their family and community structure, both from the economic and from the social, religious, and political points of view. Much can be contributed by using the information gained from the experiences of the United States Peace Corps.

I wonder, too, whether there is not a source of manpower, neglected until now, in retired people who at one time worked in the field of child welfare, agriculture, or industry, from whose wisdom and knowledge we could profit. I know, from my own experience, how valuable these people are and the excellent job they could do if given a chance.

New aspects in child welfare policy will also arise in developing countries. We can foresee that the movement of youth brigades will increase, either on

the pattern of those in Yugoslavia and Poland, or with a character of their own in such countries as Ghana and the Congo.

In many underdeveloped areas, not much is done for the girls in need, but this situation will quickly alter as it has already, for example, in Egypt, Morocco, Ghana, Nigeria, and India.

The developed countries' nongovernmental organizations which have international programs could, and should, help more than they have until now to establish national councils of voluntary child welfare agencies, a practice advocated for many years by the International Union for Child Welfare. Such national councils can, in cooperation with the governments, play an important role in the planning and improvement of child welfare standards, policy, and programing. A good example is in India. In this way, the voluntary groups can encourage a democratic approach.

All international action to improve child welfare should be directed to giving the leading people in developing areas a chance to "do it themselves," in their own way, adapting child welfare principles to their own situation and style of living.

Although society in underdeveloped areas is mainly a "man's society," much depends, in the field of social services for families and children, on the cooperation of women. Help given to women through pilot projects in such simple things as environmental hygiene, home economics, child care, improved nutrition, sewing, weaving, spinning, dressmaking, toymaking, and the like, can be one of the most forceful contributions toward better child welfare in both rural and urban areas. In Africa, where many women are engaged in trade, the introduction of kindergartens near the markets could help the well-being of millions of children and mothers. The same applies to crèches, day-care centers, and simple playgrounds in the shanty towns of the low-income countries. The greatest success is to be expected from the "step by step" programs which start from the bottom and develop progressively.

The best training plan for the child welfare workers from underdeveloped countries does not seem to be to send them to the Western countries, as the training acquired there does not seem to stir up their imagination and ability, nor teach them the knowledge and skills they need for working in a country with limited resources and shortage of skilled manpower. The Western way of thinking and acting is based too much on the individualistic and psychological approach, to be of use in the underdeveloped areas which require a more social pedagogical approach.

Western training centers, however, should be used for people working with physically and mentally handicapped children.

The care for children outside their homes will develop along its own lines. Foster care in developing countries cannot be compared with the basic Western idea regarding placement techniques and criteria. It is to be expected that emphasis will be directed more toward improving the local customs in the upbringing of children by the members of the family or of the tribe.

Concerning institutional care, the psycho- and group-therapy approaches will have few chances of being adopted, because of lack of experts and the great difficulty in providing facilities for the education and care even of normal children.

In the developing countries, the old customs and traditions, even though still dominant, are wavering under urban influences and the effects of formal education, but this does not mean that there is a value vacuum as there seems to be in the West. New countries have their ideals and belief in the future. In this period of changing values, some political leaders may misuse the young people, who are disappointed that independence has not brought a speedy improvement in the standard of living by leading them toward aggressive Chauvinist ideals. However, many other leaders represent a much sounder image for the youngsters, as they serve their country and their people with dignity, self-discipline, and without aggression toward other countries.

I have here only touched lightly upon the problems that exist in the field of child welfare from an international point of view. Even so, I hope that I have indicated how fascinating this work is and especially what could and should be done to achieve greater cooperation between those working in child welfare in both developed and underdeveloped countries so that we may live up to the principles embodied in the United Nations Declaration of the Rights of the Child.[2]

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[1] Pate, Maurice: Future directions of UNICEF. *Children*, September–October 1961.

[2] Declaration of the rights of the child. *Children*, March–April 1960.

COMMUNICATIVE DISORDERS IN CHILDREN

DONALD A. HARRINGTON

Consultant, Speech and Hearing, Division of Health Services Children's Bureau

COMMUNICATION is a process defined somewhat differently by the disciplines of engineering, sociology, physics, public speaking psychology, and others. No single definition is likely to suit all of these fields; essentially, *communication is a process of transferring meanings from one person to another.*[1]

In this article the term "communicative disorders," as used by speech pathologists and audiologists, refers to impairments in speech, hearing, or language.

How soon can a communicative disorder be recognized in a child? How soon shall something be done? What should be done? Who shall do it? A discussion of these questions requires an understanding of the normal development of communication.

Speech

Communication begins when the baby signals his arrival into the world. For a period of 3 or 4 weeks his crying, at first, is simply a reflex action and, to our ears, is undifferentiated. His parents cannot always tell whether it means he has hunger pangs or pants problems, but by the end of 3 months both baby and mother agree that certain kinds of cries are to have different meanings. By this time, he has developed a rudimentary monitoring system whereby both auditory and kinesthetic stimuli constitute feedback clues which are used to modify his vocalizations to express different meanings. At this stage too, the baby begins to repeat consonants and vowels in a random fashion, without any linguistic purpose. Most speech authorities refer to this as the beginning of the babbling stage. When the baby is about 6 months of age, this vocal play increases and inflectional patterns appear. Around the ninth month, he begins to repeat sounds in a more differentiated, less random, way. Repeated syllables become meaningful, such as "mama" and "bye-bye," etc. His vocal pattern reflects the fact that through listening he has been learning to mimic and echo what he hears. At 12 months his one word may stand for a whole sentence to the listener who understands the context.

Then the baby's rate of linguistic growth begins to spurt. The jargon he uses, although it is largely unintelligible, does not seem to be as random nor as meaningless as his early babbling. The mythical average child then begins to *talk* at one year, only if the definition of the word *talk* is not too rigorous.

Hearing

Hearing is necessary to this early speech development for if the child cannot hear he does not learn to mimic sounds and inflectional patterns, even though he may make a variety of sounds. If he cannot hear in the fullest sense of the word he does not learn that sounds are symbols. He is delayed in forming the concepts and verbalizations which mark a language system. His delay in language learning continues to

be a serious handicap throughout his life if his hearing impairment is severe.

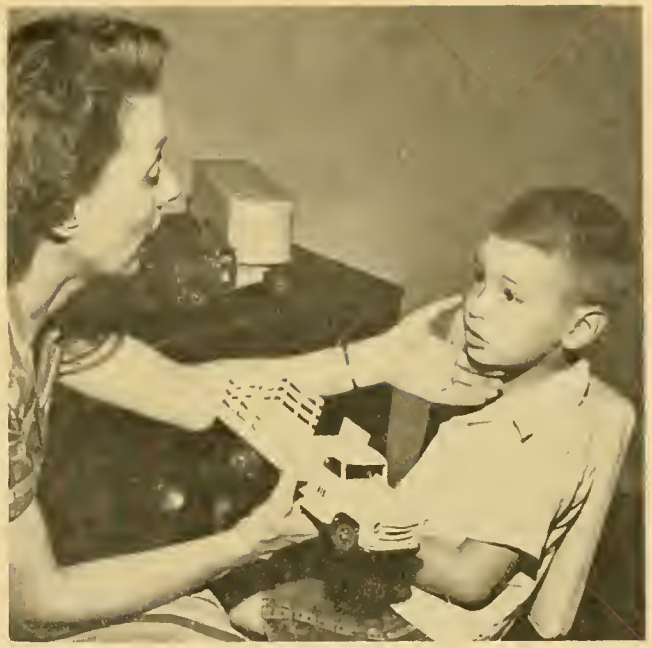
The newborn's response to sound is a blink, or a startled reflex, or a movement of his body. Between 3 and 4 months, he may respond to loud sharp noises with a gross body reflex. At about this age, he tries to locate a gentle sound by turning his head toward it. By 6 months, he responds to the quiet sounds to which he has become conditioned. Between his first and second year, if he has normal hearing, he responds to his own name and may comply with a command or a direction. By the age of 2 years, he locates and identifies familiar sounds, and responds to commands. At this age the child's hearing can be tested with a pure tone audiometer in a clinical situation by using some of the more sophisticated methods of maintaining rapport. Research is still being conducted on the infant's response to sounds. The Johns Hopkins University has just finished a new color film which demonstrates a method of testing the infant's response to sounds. [See page 126.]

As the child develops, he is more and more able to respond to specific sounds and to reproduce those sounds. He copies the language which he hears about him both in its grammatical structure and in its phonetic aspects. He learns to monitor his own speech, gradually learning to make it conform to the speech he hears.

The hearing function, of course, includes more than an acuity for loudness. It includes the function of comprehension. The development of language depends upon a complex cortical activity, including the integration of stimuli received from all senses. Other sensory impairment, as well as a hearing impairment, such as the deprivation of visual, tactile, and olfactory stimuli, may affect language development adversely. These senses are important to the development of concepts.

Language

Normal language development begins when the child learns to modify his crying to get desirable responses from his environment. This crude symbol system is quite efficient considering the infant's limited needs and his limited environment. As a child becomes more independent—creeping, standing, and walking—he has to make a wider range of responses toward his environment and also he seeks more discriminate responses from others. His language-symbol system must grow rapidly in both verbal and nonverbal aspects to keep pace with his social achievements.



Props as well as techniques are sometimes needed in working with children with communicative problems. Here the speech therapist uses a truck to evoke a response from her patient.

Parents respond to the child's different noises in an increasingly precise way. These reactions help the child to become conscious that a language system exists. His vocal play is repeated by his parents and he soon learns to expect a pleasurable reaction from talking or other communicative actions. He becomes conditioned to specific auditory stimuli so that these stimuli become meaningful. Later these signals become generalized in their meaning and the child begins to build his language without having to be taught every single word. At 9 to 12 months the average child comprehends a great deal of what he hears. He relates symbols to objects, responds to commands, and understands questions. His own words do not have a sentence structure as yet, but by 3 years he uses language very well.

However, until cortical levels are fully developed physically, true conversational speech should not be expected. The child who has not developed normally in other respects should not be expected to be ready for speech at an early age.

This brief look at the development of communication applies to the mythical average child. Although individual variation is great, the sequence of development is fairly uniform. If the child cannot achieve a further level of development, his communication problem requires a thorough diagnostic evaluation

in order to determine the etiology, prognosis, and treatment.

Disorders

Communicative disorders can be considered under the main divisions of impairments of speech, hearing, and language. Speech impairments include defects in articulation, voice production, or fluency of speaking, such as stuttering. By far the most common defects are articulation errors in which sounds are omitted, or distorted, or substitutions are made. In the normal maturation of articulation, those sounds which are made with two lips and which are easily visible such as b, p, m, and w develop early and are least likely to be incorrectly used. Some of the back tongue sounds, for instance, the k, g, and h, may be heard first. The tongue-tip sounds such as t, d, and n develop later, and those which require fine motor coordination to produce friction noises such as the s, z, and th develop still later.

The blending of consonants such as the *bl* of *blue*, the *fr* of *free*, and the *st* of *stay* call for even more intricate muscle adjustments and therefore children may be able to sound the consonants correctly without being able to put them into blends. A child who has just a few sound errors, who substitutes one sound for another, omits a few sounds, or distorts some of them, generally makes these errors on the sounds which are latest in normal development. Connected speech is characterized by the blending of the sounds at the end of one word with the sounds at the beginning of the next word, thus making a phrase sound like one long complicated word. A child may have difficulty in understanding such a message, let alone reproducing its parts.

Although the child of 1 to 2 years is not expected to be clearly intelligible to everyone, a 3-year-old should be fairly intelligible and the 4- to 5-year-old should have good intelligibility. Children who have such serious articulation problems as to be very unintelligible are frequently categorized as having delayed speech. Such children are very likely to be delayed in language development too. Furthermore, they may be delayed in many other aspects of growth and development. Therefore, a careful evaluation of the child's growth and behavior is important in making a decision about the nature and severity of the communicative disorder.

The search for causes is particularly important in making a differential diagnosis of communication problems. For instance, if the child has a hearing loss of a conductive type, the prognosis and treatment are different than when the child has an impairment of the sensory neural type. In the latter case, the auditory stimulus may have been distorted when presented to the cortical level, not just diminished. Of course a hearing impairment at the cortical level in which the meaning is not comprehended at all is still a different problem. If the cause of a communication problem is a cleft palate, different services are needed than if the cause is brain damage which resulted in muscle incoordination, or in cortical dysfunction without motor involvement. Such causes as mental retardation, or emotional disturbance, or the influence of adverse environmental factors result in different kinds of communication problems which require different kinds of treatment.

Needs

What are some of the needs of the child with a communicative disorder? Specific needs for each child will become evident as he is studied, but there are, however, some basic needs which can guide professional personnel in applying their knowledge of their own field to that of communicative disorders.

First, the most pressing need for the child with such a problem is for the problem to be identified and evaluated properly. It is not enough for a speech therapist to state that a speech problem exists, or for some other professional person to guess that the child will "grow out of it." For example, take one of the speech defects which is spoken of as a *simple* lisp. If this defect is treated as a problem in faulty learning, certain habit breaking and habit forming techniques might be recommended as therapeutic. But if the child who lisps has a mother or father who also lisps, then certainly the defect must be evaluated differently. Perhaps the child lisps only under emotional strain during which time other behavioral patterns also regress toward an infantile pattern. If a child has a severe malocclusion along with tongue thrusting habits, the lisp must be evaluated in a different category than *simple*. Clearly, the child with a lisp needs the benefit of services from disciplines which deal with both physical conditions and behavioral relationships.

Early identification of a child with a potential communication problem is not always possible, but there are some indicators. For example, a child who has a cleft palate will invariably need special speech help. Children with sensory or motor dysfunctions at birth are very likely to need help even though not all physical conditions affect the speech and hearing mechanism directly. Other examples

of children whose communication problems need to be evaluated carefully are those who appear to be mentally retarded, or emotionally disturbed, or whose environment may be lacking in the kinds of conditions which stimulate speech.

Other indicators that a child might eventually develop a speech problem may not be definite signs but nevertheless deserve attention. For instance, if the infant exhibits difficulty in nursing, the motor and sensory development of the oral mechanism may be at fault. Speech development depends upon the proper development of other activities too, such as biting, chewing, bubbling, and sipping. All of these activities occur within the first year. Failure of a child to respond to noises and voices may suggest a hearing impairment either in receiving sounds or in reacting to sound stimuli. If a child's vocalizations do not develop through the stage of playful babbling to a stage of inflectional changes, this too may suggest a hearing problem. If he cannot imitate sounds, does not comprehend, or cannot produce meaningful sounds, he is not *going* to have a speech impairment: he already has one. The first need then is that the communicative disorder should be identified and evaluated early so that the family can provide the appropriate services and training at the time when the child is ready.

Stimulation and Motivation

The second need of the child with a communication problem is to be stimulated. If he has a loss of auditory acuity, he may need a hearing aid. Visual stimulation can help him get the meanings of what others are trying to convey. If he has a loss of visual abilities, he needs special attention, for vision helps to develop the language system of symbols. He needs kinesthetic stimulation so that his oral structure becomes sensitive to the positions of the sounds produced. Any sensory impairment can affect the development of language concepts. Therefore, the child needs additional clues to reinforce those that he does receive.

He will need the stimulation that comes from parental responses to his noises. This encourages the development of an awareness that sounds can become symbols. The child needs to have his parents engage in vocal play with him: not to have them engage in baby talk, but rather to encourage him to make whatever noises he can make. It seems like a fairly simple thing for a parent to talk with his child, and it is, providing the child talks back. But even when the child does not verbalize, it is important for his parents to continue to talk to him. Speech stimulation can be enjoyable if it is made interesting with rhymes, jingles, songs, and word games.

The child's third need is to be provided with motivation. The strongest source of motivation is success.

As a first step in assuring success, parents should accept, reinforce, and reward speech attempts. On the other hand, they should not be so "accepting" that the child continues to use distortions which he could overcome. Since the child must feel that he is succeeding in communication, it is important to reduce goals to a realistic level. Phonetic precision is not a necessity. Speech which is too difficult for the child should not be expected. This kind of stimulation may lead to frustration and withdrawal: it does not promote learning. Acceptance of some phonetic deviation is necessary in order to give the child the kind of permissive environment in which he can learn. This creation of a feeling of belonging and security is an important first step in any therapy program.

The second step to success in learning is to help the child develop an awareness of differences. He should be taught the meanings of different sounds, but training in meanings should not be limited to acoustic differences. The differences in size, shape, texture, and color are important learning steps, especially to a child with a language difficulty.

The third step to success in learning is to help the child in using whatever speech he has. Situations should be set up to stimulate the child to use whatever speech he *can* in meaningful communicative attempts, not just in practices and drills. Such opportunities for him to succeed must recur regularly.

A fourth step to success is to try to reduce psychological barriers to the child's development which stem from frustration, bewilderment, anger, and hostility.

All of these steps can be met to some extent by the child's parents, and all of them are the proper concern of many different professional workers.

Parents, of course, need encouragement and counseling. They need information about their child's physical and emotional status, and his potentialities for overcoming his problem. They need someone to talk to who will take time to sort out their unreasonable fears from their reasonable anxieties. They need instruction which emphasizes the significance of other aspects of growth and development to the process of communication.

Children with voice disorders and stuttering have different specific needs from those who have articulation problems, but the principles discussed are equally significant to all communicative disorders.

The child with a hearing impairment especially needs stimulation by auditory, visual, and kinesthetic means. If the impairment could be removed, such a child would be free to learn. The responsibility, then, to overcome this impairment seems crucial. Above all, the child's difficulty must be discovered early in his life. Otologists believe that from 50 percent to 80 percent of impairments are of the kind which can be reversed or modified by early medical treatment. If medical care does not eliminate the hearing problem, the child may need a hearing aid. He will need instruction in recognizing speech visually by watching lip and other facial movements. He will need special instruction, if he has a severe hearing loss, to learn to monitor his own speech by kinesthetic and other clues.

Fulfilling the needs of a child with a language problem is difficult if the problem stems from a specific impairment in the language centers of the brain.[2] The child with such a problem needs a special training program; those planned for the mentally retarded, the emotionally disturbed, or the deaf are not adequate. A careful differential diagnosis must be made to avoid providing the child with inappropriate learning experiences. If, in addition to the specific language impairment, the child has other handicaps, then the program planned for him will have to be a compromise based upon an evaluation of his assets and potentialities.

In summary, I should like to reiterate the importance of early identification of the child with a communicative disorder and early evaluation of his problem. I should also like to stress the importance of stimulation aimed at overcoming sensory deprivation, and at improving the environmental factors which influence speech development; and of motivating the child toward success through the adoption of an accepting attitude toward him, helping him to develop an awareness of differences, encouraging him to say what he can in meaningful situations, and reducing psychological barriers to growth as far as possible.

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[1] Hochbaum, Godfrey M.: Modern theories of communication. *Children*, January–February 1960.

[2] Hardy, William G.; Pauls, Miriam D.: Atypical children with communicative disorders. *Children*, January–February 1959.

THE MYTH OF PREVENTION

Part of our problem in effectively serving and hence reincorporating the dissident 15 percent [of youth] in the past has been the illusion that by working with the most domesticated conforming easy-to-reach, the number of less conforming hard-to-reach would somehow diminish. This is the myth of prevention which mistakenly applies a concept suitable to public health to social welfare where it is wholly inapplicable. You can inoculate a healthy man against smallpox and predict accurately that he won't get the disease. You've saved him and yourself a hard time. Unfortunately, nobody can tell us what you can do with a healthy young child that will enable you to accurately predict that as a consequence of your action that child will not join the exiled as an adolescent. . . . I submit that to address ourselves to a problem, we must name it and work with it. In the present instance it is the problem of alienated youth. To develop a social strategy for the solution of this problem, there must be an analysis of its social, cultural, economic, and psychological roots. . . . Such a strategy must be designed to counteract the forces of racial, social, psychological, and economic discrimination that push young people out of the aspiration of the larger society.

Bertram M. Beck to the 1961 forum of the National Conference on Social Welfare.

AUTISTIC CHILDREN IN A DAY NURSERY

MARGARET LOVATT

Executive Director, West End Creche, Toronto, Canada

A RESEARCH STUDY carried out from 1953–55 at the Hospital for Sick Children in Toronto, over 200 children from the Toronto area were found to be suffering from some form of childhood schizophrenia. Moreover, there was reason to believe that the community contained many more schizophrenic children. No treatment facilities for such children were available.

A large number of the known schizophrenic children were of preschool age and were described as "autistic" because of their isolation and withdrawal from contact with people. Unresponsive even to their own parents, they seemed to live in a dream world of their own, unrelated to reality. They appeared mentally retarded, and most of them lacked speech. They were unable to play. Our child guidance clinics were reluctant to serve such children since experience had shown that play therapy sessions, even when tried over a long period of time with such children, had produced little constructive results.

Authorities had indicated that if a schizophrenic child had not developed speech by the age of 5 or 6 years, the possibility of his improvement was slight.[1] An attempt to help these children in the early preschool years before their patterns of behavior and the family relationship and interaction patterns had become fixed, therefore, seemed urgent. It was urged that the community set up a pilot research and treatment service for them.

About the same time the West End Creche—a day nursery which provides a modern nursery program for normal children and specialized care for a few handicapped and disturbed children—was eager to provide a special service and research project based on a significant community need. Therefore the director of the Canadian Mental Health Association proposed that the crèche establish the much-needed day treatment center for preschool autistic children. In the center these children would have the benefits of a nursery school environment, the help of the trained nursery staff long experienced in working with preschool children, and the opportunity to be among normal children who would provide both stimulation and an example for them.

The crèche's psychiatric advisors made it clear that serving autistic children would be a long-term, demanding, and possibly unrewarding project; that there was little in the way of precedent to follow, and little in the way of success to be expected, for methods of treatment tried elsewhere had not produced any marked degree of success. Nevertheless, the agency accepted the assignment.

We recognized from the first that we could not "cure" these children. Our goal was to find out whether we could be of help to them, and if so, then in what way and to what degree. Could they be helped to experience at least some of the normal

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Based on a paper presented at the 1961 meeting of the National Conference on Social Welfare.

satisfactions of life and become in any real way participating members of their families, schools, and communities?

Dr. R. W. Keeler, who had conducted the hospital research, established the new treatment center within the crèche in 1956 with the advisory assistance of members of the Department of Psychiatry of the University of Toronto, and other clinical psychiatrists. Dr. Milada Havelkova took over from Dr. Keeler as medical director later that year.

At the end of the 5-year experimental period, the psychiatric advisors urged the center to continue, and a Provincial-Federal mental health grant was secured. This is supplemented by the United Community Fund, donations, and parents' fees.

The center provides care for 10 children, 5 children in the morning and 5 in the afternoon, each child attending 4 days a week. Because of the nature and severity of the illness, treatment for most of the children needs to be continued for at least 2 years. The age range at the time of admission corresponds with that of the nursery school children—3 or 4 years—so that if the children progress they are ready for kindergarten or first grade when they leave the center.

Staff Roles

The psychiatrist, who spends half of each day at the center, directs the total treatment program. This is organized around the usual staff team. However, the roles of the staff members have been somewhat changed.

The direct work with the children is done by the nursery teacher-therapists under the supervision of the psychiatrist, who observes the children regularly and holds a weekly consultation with each teacher. Each child has his own individual teacher-therapist for the 2 hours he attends the center each day, as well as his own playroom.

At least once a week the psychiatrist meets with the caseworker, who works with the parents. The psychiatrist also has periodic interviews with the parents, held jointly with the caseworker, to discuss the child's progress.

The caseworker holds weekly case consultations with each teacher. Two staff conferences are held each week—one for case discussion, and the second for more general purposes such as the discussion of methods, staff education, research, or planning. Neurological, psychological, speech, and some research services are secured when needed from the various health services in the community.

Our recognition that we cannot "cure" these children, is based on the belief that there is a biological factor involved in the illness, and that environmental factors only alter and possibly intensify the expression of the disease. The possibilities of successful treatment, therefore, seem to vary with the relative degree of biological and environmental involvements.

For instance, although treatment may help a child to get along quite well in the community, his personal relationships with people will probably remain restricted. Perhaps for tomorrow's children biochemical or other research will provide an answer to the biological problem and a means of preventing schizophrenia, or at least of controlling it. Meanwhile, the sick children of today must be given every chance to improve through experimental treatment, no matter how costly.

Two primary features of the center which, as far as I know, had not previously been used in treating such children are: (1) its setting in a nursery for normal children where the very gradual integration of the ill child into the normal group can be used as a treatment tool and in some instances as a means of motivating the child toward growth; and (2) the one-to-one relationship between the child and the teacher-therapist. The need for this one-to-one relationship in therapy seems to us implicit in the nature of the illness and the age of the children.

The Children

The children's symptoms are numerous and varied, some the opposite of others. For example, 4-year-old George was aggressive, hyperactive, and an expert at getting into difficulties. He would unscrew any electrical fixture in sight, turn on every tap he saw, and at home he would scale his backyard fence and wander off to a dangerous four-lane highway. Raymond, also 4, was an expert at evading supervision and, before coming to the center, had been given hospital treatment several times, after eating glass, drinking a bottle of tranquilizer, and darting into traffic. Rita used to inflict self-injury. Barbara bit, scratched, and kicked others. Mary, age 3, used to sit in a corner at home for an hour or more, her eyes shut tight, rocking back and forth. Attempts to contact her produced only screams and a deeper withdrawal. These are all symptoms which are prevalent among autistic children. Severe anxiety, emotional outbursts with no apparent cause, extreme negativism, and abnormal fears are common.

Although some of the children are of superior intelligence, all are immature, functioning often far

below their chronological age. A 3-year-old at admission may appear to be at an 18-month level in most functions. On the other hand, in one or more areas he may be more advanced than the average normal child. Jean, for instance, at 3 could pick up a complicated tune at one hearing, but in all else she was below a 2-year level.

These children are "flat" emotionally and do not feel affection for people, even their own parents. Their language and tears are often inappropriate. They relate better to objects than to people, and often carry around an object, perhaps a little box or a bottle, as a sort of emotional prop. Most of them either have not developed speech or do not use it to communicate with others though they may parrot phrases such as television commercials, in a meaningless way. Their play is compulsive or aimless, a mere handling of things, and seems to give them little pleasure. If left to themselves, some children may spend hours just sifting sand or bits of paper through their fingers.

Such symptoms indicated to us the autistic child's need of individual attention. Certainly in the beginning of treatment the child would not be able to make use of the group, nor would the group be able to tolerate his behavior.

As experience in treatment was gained, it became apparent that there were parallels between the treatment and educational needs of the child handicapped by infantile autism and children handicapped by physical conditions or sensory deprivation such as blindness or deafness. Through long-term training each must be helped to understand and accept the limitations which his handicap imposes, and to develop what capacities for normal living he has. Each must be helped to develop an ability to relate to and interact with his environment in a realistic and socially acceptable way.

For instance, some children who are partially isolated from their environment by congenital deafness can be taught in special schools not only to lipread but to develop speech and so become able to communicate with others. Also some children handicapped by congenital blindness, through a persistent long-term program of stimulation and special training can develop a keen awareness of their environment and take a real part in the life around them. Yet the limitations imposed by the handicaps of these children remain very real. Similarly through the development of a dependent trusting relationship and a long-term educational program, the teacher-therapist in our center tries to lead the autistic child into a greater awareness and understanding of his environment (personal and otherwise), to help him accept the limitations imposed by his illness, and through persistent repetitive training and support, to help him learn how to cope with his environment in a more realistic and socially acceptable way.

Beginning Treatment

When the child first comes to the center, the mother stays in the playroom with him and the teacher-therapist until he feels comfortable about separation. The therapist begins with a very permissive program, feeling her way, following the child's lead, testing out his responses, and adapting her methods to his particular and changing needs—trying to reduce his anxiety with acceptance and reassurance. She uses stimulation to draw him out from his haven of withdrawal, trying to get through to him through the use of whatever objects seem to give him at least some small satisfaction and to focus his attention for at least a moment or two.

The teacher often begins with mechanical objects, for which these youngsters usually have an obsessive fascination, such as anything with wheels—a truck, an eggbeater, rings, or bottle tops. Instead of playing with these as would a normal child, the sick child usually just spins them around or pushes them back and forth endlessly. Through using these objects with him, the teacher tries to rouse him into an awareness of herself, and then to some interest in other playthings and activities. For instance, the teacher might take a truck whose wheels the child is spinning, pile blocks in it and get him to dump them out; or get him to mix soap bubbles in a bowl with his eggbeater, encouraging him to accept a few simple directions. All the while the teacher helps the child to examine and experiment with each new object, to gain at least some slight satisfaction from it, and to learn something of how it can be used.

By keeping the child in his own small playroom in this early period, the distractions are reduced and the teacher is better able to hold his attention on herself and what they are doing together, and thus to keep him from withdrawing into his inner world. Gradually as the child becomes aware of his teacher, and as he develops some sense of confidence in her, more structure can be developed in the program activities and a few more limits set. Generally these youngsters, because of their anxiety and disorganization, are more comfortable and make better progress in a fairly structured program. They need the firm support which routine and structure impose, but

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these must be planned to meet each child's individual needs.

Throughout the child's attendance at the center the teacher continues the patient, oft-repeated explanation of things which arouse his anxiety, or of concepts which he finds difficult to grasp although they may be grasped quickly by a normal child. The schizophrenic child, for instance, finds great difficulty in distinguishing between the characteristics of inanimate objects and people. It takes time and repeated explanation for him to learn that it hurts a child if you kick him but it does not hurt a ball. Because concepts of space and time are difficult for him, he may try to squeeze himself into a tiny box and fail to understand why things which are to happen in an hour do not happen right now.

When the therapist has been able to establish some degree of relationship with the child so that he trusts and depends on her, she begins to lead him into a wider environment and among other people. He begins to move about the nursery building and playground, but under close supervision. If not closely supervised, the child without a sense of danger might walk heedlessly into moving swings. Another child may be so fearful of everything that for weeks he will venture onto a swing or go down a slide only if he is held firmly on his teacher's knee. Gradually he will find enough courage to go by himself.

In the Nursery School

As the child develops an ability to use his therapist's help, to accept some limits and direction, he may begin to visit in one of the normal nursery playrooms for a few minutes—at first perhaps while it is empty and later while a few children are there, but always with his nursery therapist close at hand for support. As he begins to tolerate or respond to this experience, the visits are lengthened and increased in variety. At first he may appear to ignore people who see him and greet him; he may "look right through them." If given free rein he may walk into a playroom, brush from a table whatever the other children are playing with, pile up a lot of toys and knock them down, circle around the room and leave, having looked at no one, child or adult.

When he is being introduced into the nursery school the therapist tells and shows him what is expected of the children there—the basic requirements of the playroom—and he is helped to meet these expectations as far as possible. Naturally there is great flexibility in the demands made on him, but the length of time he visits in the nursery playroom each day is gauged by his ability to conform at least to some extent to its basic requirements. Gradually he begins to "see" the children, to watch them, to begin to imitate them.

Play usually continues for a long time to be of a parallel type—the autistic child copying the other children rather than joining them in their activities—but some of the sick children (though not all) learn very gradually to take part in group activities, such as the music or story circle, although their performance may be erratic. During this integration in the normal nursery, the ill child has an opportunity for practice not only in using play materials and equipment but also in the difficult field of personal relationship. He can learn some of the social skills which the normal child learns, but for him the process of learning is much slower, and his hold on the skill much less sure.

In our nursery's experience the relationship between these children and the normal children has in no instance become very close as is often true of two normal children. However, some of the autistic children have gradually become able to interact with other children, to cooperate in play or in a chore on a more or less surface level, and to gain real enjoyment from the joint activities.

We have frequently been asked how the normal children react to the autistic children, and whether they are affected by the latter's unusual behavior. In order to maintain the "normalcy" of the group (for the sake of both the normal and sick children) we early established a policy allowing no more than one autistic child into any nursery group. Moreover, if the sick child's behavior becomes seriously disruptive, his therapist will take him out of the group to some individual activity. In these circumstances we have not found the normal children adversely affected by the behavior of the ill children. They do observe the strange behavior, and occasionally a child may even consciously imitate it once or twice, but finding therein little satisfaction he soon reverts to his own normal pattern.

The normal children do not show resentment when limits are sometimes stretched a bit for the sick children. In fact they are usually pleased to be helpful to them. While scarcely a day occurs without at least one parent of a normal child observing in the nursery school, we have never had a protest or expression of real anxiety about the influences of the ill children.

Throughout the period of integration into the nursery school, the therapist-teacher continues to

work individually with the child for part of each session, very often alone with him in his own small playroom. She continues to help him use his relationship with her to reduce his anxiety and fears, increase his skills, build his self-confidence, develop his speech, and adapt himself to normal social demands.

If the child continues to make progress in fitting into the nursery group, then the therapist begins to refer him to the nursery group teacher for direction and help. If he accepts this, then the new relationship is gradually built up and more and more responsibility for working with him is turned over to the group teacher, and the therapist gradually withdraws. This process takes many months.

Some of the sick children who achieved integration in the nursery school have been ready at the age of 5, others at 6, to test their new-found selves in the more demanding setting of the public school kindergarten. Before the child enters kindergarten, the center seeks the cooperation of the school, interpreting the child's special needs, and offering consultation from its psychiatric director. After the children leave the nursery, we continue our contact with them, their families, and schools for followup study.

All the children who started kindergarten after treatment have so far managed to continue at school, although in some instances despite considerable adjustment difficulty. Four of our first "graduates" are now in the second and third grades and are doing remarkably well. Since they progressed steadily after the difficulties of initial adjustment in kindergarten and grade one, it is hoped that the children now in their first and second years at school will also progress in the educational program. It is, of course, too early and too uncertain to make predictions.

Diagnostic Observation

During the past 4 years, the center has also provided a diagnostic observation service. We are now admitting two children each month for observation and have a long waiting list. Autistic symptoms in preschool children may be related to any one of a variety of conditions—childhood schizophrenia, brain damage, visual or hearing impairment, mental defects, or environmental emotional disturbances, or a combination of these. It is important that the causal condition of the autistic behavior be identified at an early age since plans for treatment vary with the basic condition.

Differential diagnosis is sometimes extremely difficult. Psychological tests for such children are of little value because of the child's inability to cooperate in the tests. A history secured from parents often provides baffling or contradictory diagnostic data; and often an examination of a preschool autistic child in the psychiatrist's office may prove quite as inconclusive.

In cases where the diagnostic picture is confused, the child may be referred to the center for a 4-week observation. He attends for 2 hours a day and is cared for by an individual teacher, his program being similar to that of a child in treatment. Some of the values of this type of observation are its length, the opportunity it provides for observing the child in the company of normal children as well as alone, and the long experience of the nursery staff in working with both normal and disturbed preschool children.

After the nursery's psychiatrist observes the child several times and the caseworker has 6 to 8 interviews with the parents, an evaluation is made of the child's ability to respond to people, to react appropriately to his environment, and to benefit from teaching. A conference is held with the referring psychiatrist or agency and a decision is made regarding diagnosis and possible plans for treatment or handling the child. These possibilities are then discussed with the parents and help given to them in planning for the child's care and development. Referrals are made to appropriate services.

The Parents

If the parents can achieve a realistic picture of the child's handicap and capacities, they may be able to prevent the development of further symptoms by reducing their expectations of him.

Much has been written about the "typical" personality structure of parents of schizophrenic, autistic children. Descriptive terms such as "cool," "aloof," "over-anxious," "rigid," "unsocial," and so on, have been used. It has been said that these parental characteristics result in inadequate parent-child relationships and thereby contribute largely to the development of the disease. More recently this theory has been strongly questioned, and it is becoming more generally accepted that the role of environment in the child's illness cannot be so definitely defined. In our experience, there have been parents of autistic children who have not fitted neatly into the classical picture and who have established good relationships with their other children.

Parents are deeply affected by the painful experience they suffer as they gradually become aware that

their child is mentally ill. If there is an inadequate parent-child relationship, this traumatic experience probably plays some role in its development. Even in the ill child's early infancy, his parents may feel puzzled and chilled by the child's strange lack of interest in them. As this continues, they feel deeply hurt and rejected.

In infancy and early childhood, schizophrenic children exhibit such problems as severe feeding difficulties, reversal of sleep patterns, rocking, twirling, or headbanging, withdrawal, or bursts of screaming. At times the child may be extremely negativistic. Parents may find themselves almost helpless in dealing with such behavior. As they fail to reach through to their child, they are overwhelmed by feelings of guilt and failure.

One of the primary needs of the parents, following the shock of the diagnosis, is help in accepting the reality of the child's mental illness and the inevitable readjustment that this requires in their family life and their outlook for the future. They need and want to understand the illness, its development, and its effects. What are the child's limitations? What of his future? How can they build a helpful relationship with him? They also need help in recognizing and expressing their feelings, especially toward their child and toward themselves. If they can come to understand and accept the child's limitations and adjust to a realistic level their standards for the child, and for themselves in dealing with him, then they can regain a sense of self-worth and the necessary control of their situation. The caseworker can be of real help in meeting these needs.

The caseworker may also help the parents in gaining some perspective on the often conflicting needs of the ill child and other members of the family. Sometimes where these conflicts are severe and cannot be reconciled, where treatment has not brought significant development and the prognosis is poor, the caseworker can help the parents think through the possibility of institutional care. The fact that treatment has been tried may make it easier for them to reconcile themselves to the necessity of institutional placement. In some instances the parents of ill children are themselves suffering from severe disturbances which are unlikely to respond to casework treatment. The caseworker can, however, support them in strengthening their defenses.

Throughout the child's treatment, the caseworker keeps closely in touch with the child's home experience, and the parents are similarly kept close to his experience in the nursery.

The Meaning

The role which mental illness plays in crippling and destroying our human resources has long been spelled out plainly. In Canada almost half of all the hospital beds are occupied by patients who are mentally ill,[2] and similar statistics, I believe, exist in the United States. What this means in human suffering we cannot conceive of, nor of what it represents in loss of manpower and in costs of care.

The problem is of such magnitude that it can only be fought with a concerted nationwide effort. This experimental demonstration service in a day nursery setting described here is on a very small scale, but joined to other numerous projects developing across the continent, it may prove to be of some significance in the general attack. Certainly to a number of our children it has given the chance to enjoy their childhood, and may mean for their future a sense of personal worth and a life of purpose.

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[1] Kanner, Leo; Eisenberg, Leon: Notes on the followup studies of autistic children. *In* Psychopathology of childhood. Paul H. Hoch and Joseph Zubin, eds. Grune & Stratton, New York, 1955.

[2] Encyclopedia Canadiana 1956: Mental health. The Grolier Society, Ottawa, Canada.

. . . The cause of children must always triumph ultimately. New standards of what constitutes scientific care and new knowledge as to what are the social needs of children will develop. The important thing is that we should be "on our way" toward adequately meeting their needs. Perhaps you may ask, "Does the road lead uphill all the way?" And I must answer, "Yes, to the very end."

Grace Abbott, past chief of the Children's Bureau, in a commencement address at the New Jersey College for Women, June 1934.

PUBLIC WELFARE'S ROLE IN DAY CARE FOR CHILDREN

MRS. RANDOLPH GUGGENHEIMER

President, National Committee for the Day Care of Children

SINCE a major purpose of a public welfare agency is the strengthening of family life, programs for the care of young children who cannot be properly cared for in their homes during the day must be high on the list of priorities.

Granted, a young child should spend much of his time during the day with his mother. In fact, the National Committee for the Day Care of Children is trying to make this possible for more children by urging realistic grants in aid to dependent children, by encouraging homemaker services and the development of more family casework agencies to help stem the appalling tide of family breakdown, by persuading industry to offer part-time jobs and selective hours for mothers of school-age children, and by convincing mothers of young children to delay entering the labor field whenever this seems feasible.

Day care away from home is not desirable for all children any more than foster care is. It is a service for those who need it—and for many children it offers far more than their homes ever could. The tragedy is that it is not available for large numbers who *do* need it—that it is too often misunderstood, badly financed, and operated without regard for the terrifying dangers of poor standards.

The kind of day-care program for which public agencies must accept more responsibility is a program with a careful intake policy that accepts children because this is the soundest plan that can be made for them, and that is able to provide expert help in working with the family to remedy the situation that made day care necessary.

Good day-care programs incorporate the best health and educational standards applicable to the age group served. For example, they provide family day care (care of individual children in a daytime foster family) for children under 3 as well as for children over 3 for whom the long day in a group situation is not desirable. Family day-care services lean heavily for their standards on standards for full-time foster family care.

A good day-care program also provides centers for the care of children in groups. A day-care center is not a nursery school, or a group work or recreation service, although if established for preschool children it may incorporate the kinds of programs that are present in good nursery schools, or, if for school-age children, the kind of skills that are used in group-work services. However, for children who are away from home most of the day there must be additional services to compensate for the lack of home and parental contact. In other words, there is some element of need present in the family of the child for whom day care is indicated. Many of these children have personal problems and many face home situations that must be taken into careful consideration in planning and carrying out daily schedules. This requires broad understanding and skill in working with children.

The admission process is extremely important. A good day-care program must have attached to it the kind of skillful counseling service that will help families at the point of intake to reach the correct solution in selecting day care or making some other choice for themselves and for their children.

Good day-care programs are conducted in rooms that are well-ventilated, well-lit, and above street level. Outdoor space as well as indoor space is

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Based on a paper presented at the 1961 National Biennial Round Table Conference of the American Public Welfare Association, Chicago.

large enough for active play and equipment is plentiful, readily accessible, and carefully selected to provide the tools a teacher needs to help children learn and to give them an opportunity to develop intellectually and physically as well as emotionally. Staff trained in handling children are present at all times. Children from 3 to 6 are served in groups, each having a teacher who is an expert in the field of early childhood education. The groups of preschool children are small enough to allow a relationship to be established between the teacher and the individual child. For instance, groups of 3-year-old children have no more than 15 children to a teacher and assistant. Two-year-olds are in family day care and not in group programs.

These are some of the standards for day-care programs recommended by the Child Welfare League of America.[1] Unfortunately, however, they can at the present time be properly classified only as goals, for few centers have reached them.

Good day care is expensive. It may cost as much as $1,000 a year per child. It is, of course, not as costly as full-time congregate care, residential treatment for emotionally disturbed children, mental institutions, correctional care or even public assistance.

Bad day care on the other hand can be as damaging as the absence of care. Its presence lulls us into believing that the child is being safeguarded when actually intellectual and even physical destruction may be taking place.

The Need

Considering the cost of good day-care programs, the need must be great if public financing or administration is expected to be involved. Unfortunately, we have very little accurate information on the full extent of need. We do know, however, that when a day-care center is established in an area accessible to low-income housing, and when the fees are within the reach of nearby families, authenticated waiting lists run high. We also have strong reason to believe that where no services exist, families are making poor or even dangerous arrangements for their children. We find documentations of this in the newspaper stories of family catastrophes, as when a house catches fire and young children are found at home alone—or we find this in the numbers of unsupervised young children whom we see playing on our city streets, in migrant farm camps, or in military installations.

These are visible, if unscientific, evidences of what seem to be rather widespread neglect of young children. But we also have some startling figures collected 3 years ago by the Bureau of the Census for the Children's Bureau,[2] in an effort to find out what was happening to the 5 million children under 12 whose mothers were working full time. Based on a sample one-day survey, these figures indicate that 1 out of every 13—or more than 400,000 children—were left to fend for themselves while their mothers were at work. Of the children who were not left entirely on their own, 558,000 were cared for in their own homes by relatives under 18; and 647,000 were cared for through arrangements other than through regular mother-substitutes or group care. Such arrangements ranged from working with the parents chopping cotton in the fields to haphazard shifting of the child among various relatives. The largest percentage of children caring for themselves came from farm areas where it is often assumed that day-care services are unnecessary.

Figures from the Bureau of the Census, obtained in a 1959 survey, indicate that 14,700,000 children under 18 in the United States had mothers who were employed either full or part time.[3] Nearly one-fourth of those who are in husband-wife families had mothers who were employed; while almost half the 5½ million children who lived with their mothers only—including 621,000 children under 6—had mothers who were employed. Of the working mothers in these one-parent families, 44 percent had incomes under $2,000 a year; an additional 39 percent had incomes between $2,000 and $4,000 a year.

Trends in the employment of women offer little promise of a decrease in the number of mothers in the labor force in the foreseeable future. In March 1958 there were 80 percent more women with children under 18 in the labor force than there were in 1948. In 1890, married women constituted 13.5 percent of the number of women who were working; in 1959, they constituted 55 percent. At the end of World War II, Federal aid for day care was discontinued because it was confidently expected that women would return from defense industries to their homes. Yet there are 3,700,000 more married women in the labor force today than in March 1950.[4] We must face the fact that our economy now depends largely on women workers.

Many aspects of our culture add inducements to women to work—including such pressures as status and its relation to material possessions, the contempt with which large elements in our society view recipients of public assistance and the bare subsistence levels of the aid-to-dependent-children

grants. The high incidence of separation and divorce and the rise in illegitimacy, resulting in a large number of families with only one parent, are also factors that are moving women into the labor field. These also create a need for day care even if the mother is not working. Children from homes where there is only one parent may have a desperate need for day care, to compensate for a distorted family picture. In March 1960, there were 5,727,000 one-parent families in the United States.[3]

In spite of fears to the contrary, evidence indicates that the presence of good day-care services does *not* act as an incentive for a woman to go to work; it merely relieves her mind about the kind of care her child is getting. A study of womanpower by Columbia University a few years ago [5] found no correlation between the existence of day-care programs and the number of women in the labor force in any locality.

Some Advantages

There are innumerable instances where a child's ability to withstand a difficult home environment can be considerably enhanced by day care. For example, mental illness in the family, especially of a parent, can be devastating in its effects on the young child. Day care for the child may be an extremely important aid to the parent's recovery after discharge from the hospital as well as an aid to the child in his relation with the parent.

Day-care programs are also needed for families in which a mother who has been denied warmth and affection in her own childhood has no inner resource for meeting the emotional needs of her child. Unless we can provide for some of these needs during early childhood, we may be perpetuating such a pattern in future generations. If we can give a child the strength to cope with a less than ideal situation without removing him entirely from his family, we have achieved the goal of strengthening family life.

Poor or overcrowded housing often makes it desirable for a child to be absent from the home during the day. The possibility that we will be able to eliminate overcrowding in our city slums, even with the most ambitious of building programs, is a very slim one. Even in our modern housing projects, space for large families has been limited to a point where at times the stability of the family can only be preserved by relieving the mother of the care of one or two children during a major part of the day.

When a child has no room to play, to run, to climb, when he is constantly underfoot, when he is denied the space and freedom he should have, his development may be retarded, his behavior may become destructive, and the tensions in the family may rise in a spiral of irritation and counter-irritation.

The mobility of families today poses additional problems for family life. Children of newcomers to a community, especially those with different cultural backgrounds, may be helped to fit into a resistant neighborhood through the use of day-care services. Cultural integration must begin early if hurt and hostility are to be prevented.

Day-care services are needed for children with such handicaps as mental retardation, blindness, cerebral palsy, heart conditions, deafness, and emotional disturbance. Some specialized centers have accomplished near miracles in helping such children overcome the social handicaps of their conditions. In addition, skilled teachers in a number of regular day-care centers have been able to help less severely handicapped children to participate in a normal program.

One age group, often ignored by planners of day-care programs, requires more attention. A large number of mothers go to work when their children enter school, and many of these children are expected to shift for themselves after school until their mothers return from work. Known as the latch-key group because so many of them wear their door keys on strings around their necks, these children are expected to be self-sufficient in environments that offer a perfect banquet of dangers—from the matchbox on the kitchen stove to the delinquent gang of older boys who hang around on the streets.

Making music is an absorbing activity in this day-care center.

Infants are the most susceptible of all groups to a lack of consistent, loving care from a familiar figure. Yet today many infants are boarded out with neighbors with a surprising degree of casualness. Their mothers are apparently going to work whether or not reliable day-care services are available in the community. If these infants cannot be at home with their mothers or a mother-substitute, it is to society's own interest to make available the kind of service, such as daytime foster family care, which can provide them with the emotional nutrients for healthy growth, without which their personalities in later life could become seriously distorted.

This then is the catalogue of need, and it can be summarized by one phrase: *the neglected child*—the child for whom, during the day, no adult is responsible, or who is left in the hands of an adult who is neither competent, concerned, or able to provide the warm relationship or opportunity for growth that every child needs.

The Public Responsibility

What then is the responsibility of public welfare agencies? As has been pointed out by New York City's Commissioner of Welfare, James Dumpson, there is need for refocusing public welfare structure from a money giving organization to a service-oriented organization for families whose needs reflect the inadequacies of our economic, social, and moral life, and for public welfare then to develop, in cooperation with voluntary agencies, a spectrum of services in sufficient quantity and quality to assure that the welfare needs of every individual can be met in accordance with the highest standards known.[6]

The family counselor or caseworker, working within this broad spectrum, must be able to help families decide what kind of day-care arrangement—whether at home with a parent or away from home—is best for their child. To make a wise choice possible, day-care services must be available.

The public welfare agency, however, must broaden its horizons. The artificial divisions existing between education, health, and welfare services have handicapped all of us who have been working to provide programs designed to use the skills of many professional disciplines and to meet the more encompassing needs of our complex society. We need a new word to take the place of "interdisciplinary," since this too often implies an artificial bringing together of skills instead of the development of a whole program. We are too often so torn by the various perspectives of the different disciplines that we twist programs to conform to departments and organizations instead of developing them to fit the problems of the people needing service. Despite the enormous growth of various kinds of voluntary and public programs, opportunities to serve are still lost in debate about responsibility. The public welfare department must be able to integrate programs with health and education aspects just as education and health departments must incorporate welfare standards.

Our concept of the role of public welfare has changed dramatically in the past 30 years. In the early thirties, when apples being sold on street corners were supposed to keep the wolf from the doors of the unemployed, there were day-care programs in almost all parts of the country. But the concept of public responsibility for them—either in setting up standards for licensing or for helping to defray the cost—was not even a glimmer in the eyes of the social planners of the day. Before the mid-thirties those day-care services which existed were provided almost entirely by private philanthropy or commercial operators without the safeguards of Government licensing. In many instances they offered only bleak custodial care, often in physically hazardous conditions. (I wish it were possible to state that such poor quality services no longer exist.)

The first large-scale public program of day care came in 1936 with the WPA, the Federal work-relief program which expired with the coming of World War II. The major purpose of this program, however, was to provide jobs for teachers, child care being only a byproduct. When the WPA program was liquidated, the Federal Government remained in the picture through a program of grants for local day-care services under the Lanham Act (War Area Child Care Act). These funds were administered through State departments of welfare and by State departments of education, but many of the services were provided by voluntary agencies on a lease arrangement. Again, the program was not provided for the sole purpose of strengthening family life, but also to make it possible for women to go into war industries. Standards of quality were regarded as important, however.

Today's concepts of the role of a public welfare department are as legion as the people and places in our country. In some areas there are misty-eyed nostalgics who would be pleased to bring back the world of the 1890's—while of course retaining television, jet travel, and cellophane. In others, there are the visionaries who would like to establish a

State in which all health and welfare services are provided by "Big Brother." Somewhere in between is a conception under which day care becomes an essential but carefully defined responsibility of government.

Day care may be helpful as an adjunct to a great many family services including public assistance. In some instances, it may be important to help a mother go to work to break a pattern of dependency.

Always keeping in mind that a long day away from home is not the most desirable solution for most small children and that the use of day care requires careful planning, we can still find many instances of families that have been strengthened through a well-planned day-care program. We have in this country been slow in accepting this fact. This is in part due to our unwillingness to realize that there are many homes where mothers are unable to give their children the affection they themselves never received as children, in part to our longing for the past when mother was in the kitchen, and in part to our unwillingness to accept the heavy expenses inherent in providing good day care. The perpetuation of the problems caused by neglect are more expensive than the most costly welfare service.

Financing

Private funds are not sufficient to make good day-care services available at fees that are reasonable enough so that the most needy consumers can afford them. Public funds are necessary for this. Unfortunately, today, public funds for day care are rare. New York City, the State of California, the city of Philadelphia, and a few other places make such funds available for local day-care services. In no instance are they sufficient to provide service to all the children needing it. Some State welfare departments are considering purchasing day-care services from voluntary organizations. The bulk of financial support, however, comes from the overloaded community chests and has been insufficient to meet the day-care needs. Federal, State, and municipal funds, and whatever private resources can be mustered all become necessary.

In addition to helping to finance community day-care services, State or municipal agencies must be charged with the responsibility for enforcement of standards for all day-care services, whether tax-supported, philanthropic, or commercial, to protect children from abuse, neglect, and danger. According to a study made by the Children's Bureau, only 33 States have laws requiring that day-care centers and family day-care homes be licensed.[7]

Where day-care programs do not exist under appropriate auspices, where they are not adequately financed or carefully supervised, where the fees are too high or the centers are not available to low income families, there are usually two alternatives for families who cannot provide care during the day: (1) to give up their children to 24-hour care away from home; or (2) to make arrangements which may result in neglect or even danger for the child, and in guilt and tension for the family. The tragedy of this is that the community too often is not aware of the neglect or danger until disaster strikes.

Those of us who have worked closely with day-care centers have a continuous goal—we hope someday that for every child in every community in this country there will be at least one adult who will have an answer at all times to the question, "Where is the child?" We hope too that whatever the kind of family a child may have, a day-care service will be available for him if he needs one to help strengthen his relationship with his family and to help his family provide something a little closer to our concept of a real home for him.

In working with other agencies—whether oriented to health, education, or welfare, on a national, State, or local level, whether supported by tax or voluntary funds—to achieve this goal, public welfare agencies will be helping to achieve what is basically the goal of all service programs: the strengthening of family life and therefore the strengthening of our kind of society.

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[1] Child Welfare League of America: Child Welfare League of America standards for day care service. New York. 1960.

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[4] Bureau of Labor Statistics, Department of Labor: Marital and family characteristics of workers, March 1960. Special labor force report No. 13. April 1961.

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DETERRENTS TO PRENATAL CARE

HOWARD B. MONAHAN
Formerly Social Work Consultant

ESTHER C. SPENCER
Chief, Bureau of Public Health Social Work

California State Department of Public Health

THE ASSOCIATION of adequacy of prenatal care to outcome of pregnancy has been well established by studies which have shown significant statistical association between lack of prenatal care and prematurity [1] and infant mortality.[2, 3] But why, in a State with widespread clinical services, should any expectant mother fail to have sufficient prenatal care?

This question has been bothering public health authorities in California during the past decade and, as a result, a number of studies of the extent of and deterrents to prenatal care have been made under various auspices in a number of counties.

In California, the 58 counties are the strongest units of local government, with considerable autonomy and control—jealously guarded by the county boards of supervisors—in regard to public health and welfare policies and the administration of county hospitals. While city health departments exist in some highly developed urban areas, there are no city hospitals or city welfare departments. While all counties do not have county health departments or county hospitals, those that do not have them make other contractual arrangements with community hospitals for the provision of appropriate hospital services, including maternity care.

Of the five studies of prenatal care to be described here, one was made by a county health department and county hospital, one by a county hospital, two by a city health department and a county hospital, and one by the State health department with the cooperation of the county health departments. All of them found that a considerable portion of women of lower income groups were either not getting any prenatal care at all or were not getting care as early as the medical profession deems necessary.

The State health department first called attention to the need for such studies in 1952 when it sponsored two working conferences of State and county public health personnel to consider ways of preventing prematurity. The State did not complete its survey, begun in 1954, until 1956, and by this time several local health agencies were already conducting their own studies. With the exception of the statewide survey, all of these studies were concerned with the coverage of prenatal care rather than with its quality.

One of the first of these local studies was carried out in Alameda County by the local health department's bureau of maternal and child health.[4] This was focused on finding out what happens to expectant mothers who are ineligible for county hospital clinic care, and yet cannot afford private care.

Cooperating in the study were representatives from three local health jurisdictions within the county, from the county hospital, and from the county medical society. For the 6-month period from March 1 to August 31, 1953, a survey of 134 patients ineligible for county hospital outpatient prenatal care was conducted involving a complete followup of 123 of them by public health nurses through the 6-week postpartum period. All 134 ineligible women had been referred by the intake workers of the county hospital to appropriate local health departments within Alameda County, but information on 11 was not available at the time of followup. While information obtained during the home visits constituted the basis of the survey, some

additional information was obtained from the birth and fetal death certificates.

The data show that most of these women were ineligible for county prenatal care on the basis of too much income or lack of residence; 59 percent were not eligible because of their income; 13.5 percent because they lacked the required length of residence in the county; and 14.2 percent for a combination of these two reasons. Of the 123 patients, more than half (66) had received either inadequate or no prenatal care. Inadequate care was considered to be care begun after the second trimester. Of 106 patients who ultimately obtained some prenatal supervision, either through private or semiprivate sources or eventually at the county hospital clinic, half were delivered as emergencies at the county hospital.

This suggests that patients who were ineligible for county care and referred to other medical care resources do not, in the final analysis, obtain sufficient care. Knowing that under the law the county hospital has to accept them if they come to delivery as emergencies, many of the women make no other arrangements for care.

In Los Angeles

In connection with an inquiry into the eligibility of its obstetric patients, the Los Angeles County General Hospital briefly reviewed the prenatal care histories of all women who gave birth there during one week in April 1954 and found that one-third had received no such care.[5] Since prenatal care was being offered in 32 health department clinics in the Los Angeles area for women financially eligible under the standards of the Los Angeles County Department of Charities, the State Department of Public Health was interested in knowing why care was not obtained. Therefore, a social work consultant on the State staff interviewed 413 mothers about two days after delivery to find out how much prenatal care they had received and why certain mothers had received little or none. These interviews took place from mid-February to mid-May 1956. Each mother was asked to give information about race, marital status, education, and the amount of prenatal care received. Each mother who had gone to a doctor or clinic no more than once, or not at all, and one-third of the mothers who had gone more than once—199 mothers in all—were asked a further series of questions geared to reveal their attitudes toward prenatal care. Those who had not seen a physician were asked why not.

Some of the highlights from the summary of this study were: 51 of the 413 mothers interviewed, or 12 percent, had not been to a doctor or clinic for prenatal care during the current pregnancy; 39, or 9 percent, had made only one visit. Of those who had had some prenatal care, one-third began care in the first trimester of pregnancy, and about one-fourth waited until the third trimester; 65 percent who had received care had attended a health department clinic, and 16 percent had visited both clinic and private doctor. There appeared to be no difference in classifications according to ethnic groups, residence, or marital or employment status as to number of prenatal visits made or the time prenatal care was begun. The mothers who did not get prenatal care consisted largely of the less educated, the older aged, the users of public transportation, and women who lacked prenatal care in a previous pregnancy.

Among the 51 mothers who had had no care, four were having their first child; 22 had had no care during a previous pregnancy; and 9, some of whom had had several pregnancies, never had care in any pregnancy. Three-fourths of the mothers who had had no prenatal care were delivered previously at the Los Angeles County General Hospital. Of the 21 percent (90) who had no care or not more than one visit, 52 said there were times during pregnancy they would like to have seen a doctor.

Responses of the 199 mothers to the attitudinal questions indicated over three-fourths of the mothers who received care were pleased with it. Over half had no criticisms of the care they had received: one-fourth made some qualifying comments. One-fourth did not respond to the question. In this group, attendance at a prenatal clinic appeared to be influenced adversely by a low educational level, language problems, employment, and problems of caring for other children.

In her report of this study, the social work consultant pointed out that her observations underscored the importance of the prenatal clinic's first contact with the expectant mother. She also reported that the fact that the pregnant woman had a medical problem or was worried about the impending birth did not always motivate her to seek care.

High Risk Groups

Another survey of prenatal care was done in the San José city health department.[6] This survey was carried out by a social worker at the University of California School of Social Welfare, Berkeley, as part of her training in a project sponsored by the

Bureau of Public Health Social Work, California Department of Public Health. Briefly, it sought to determine the reasons why 435 of the 3,948 San José residents who gave birth to live babies during 1958 had had no prenatal care or had deferred seeking care until the third trimester of pregnancy. These mothers were found more often to be teenagers having their first babies, grand multiparas (women who had already had 4 or more children), and mothers over 40 years of age.

Social Factors

The study attempted also to determine whether a relationship existed between the trimester in which prenatal care was begun and such social factors as established residence, knowledge of resources, educational level, religion, and ethnic group. A sample of 30 mothers were selected for individual interview.

Among the women in this sample, the average length of San José residence was 11 years, the average educational achievement was ninth grade, and the average family income was $3,100 per year. Their housing was for the most part "adequate to meet family needs" but few were equipped with telephone, radio, or TV. Most of the husbands were unskilled seasonal laborers. Two-thirds of the women in the sample belonged to minority groups. Over half were of Mexican origin, a cultural group not accustomed to seeking early prenatal care.

Of the 30 mothers interviewed, 4 had had no prenatal care; 5 were ineligible for service at the county hospital, but later were admitted for delivery as emergencies. Three mothers said they did not know they were pregnant until late in pregnancy; 2 said they had not wanted to go for care but gave no reason; 10 said they had no one to care for other children while they were gone; 5 said they saw no reason to go for care since they were not sick; 5 said they put the beginning of care off to save money for delivery by a private physician. All expressed satisfaction with their hospitalization.

Of these 30 mothers, 5 were receiving public assistance through the aid-to-dependent-children program; but the 25 others had had no social agency contact. Twenty of the mothers had contacted both the health department and county hospital in seeking obstetrical care. Except for 3, all were markedly dissatisfied with the hospital's prenatal clinic. Their complaints in the order of frequency were: (1) "Social workers don't talk nice to you"; (2) "Can't see a doctor right away"; (3) "Wait in the clinic is too long"; and (4) "Too hard to get there by bus by 8 o'clock when you have to get someone to stay with the children."

The survey concluded that the financial factor seemed to deter the majority of these mothers from getting prenatal care. While they were ineligible for such care from the county hospital they had inadequate funds for obtaining private care. Of the 20 mothers who had delivered at the county hospital, 15 were billed and were trying to work out arrangements to pay. This problem, the social worker suggested, might deter these mothers from seeking early care in future pregnancies.

A second important deterrent was the problem of finding someone to stay with younger children. Other deterring factors were chiefly emotional or related to poor understanding: fear of doctors; not knowing of pregnancy; dislike of the clinic; or deeming prenatal care to be unnecessary.

Briefly, the major deterrents observed in this study were a combination of external obstacles, inadequate perception of what prenatal care involves, and dissatisfaction with the clinic's procedures. The social worker who carried out the study suggested that it might be easier to minimize the external obstacles—for example, by liberalizing intake policies at county hospitals with respect to residence and financial eligibility—than to overcome the attitudinal deterrents. She pointed to the need for greater efforts by health departments and medical societies to publicize the importance of health supervision for the three high risk groups; and added that identifying the grand multiparas and pregnant women over 40 is not so difficult as finding the pregnant teenager, usually primipara and therefore without a prior health department contact. Once these expectant mothers are located, the social worker suggested, more time and effort with each by the clinic staff to determine her perceptions of care and to overcome obstacles might be effective.

A Wider Study

In 1958, the Los Angeles City Health Department conducted a survey to determine the extent of prenatal care among County hospital maternity patients and "to identify the geographical areas and sociocultural groups where unmet needs are greatest."[7] Nearly one-fifth of all city resident births in 1958 occurred at Los Angeles County Hospital.

The motivating factors for this survey were: The hospital's perinatal mortality rate was 60 percent higher than the rate in the rest of the county. Furthermore, the infant mortality rate for nonwhites,

who are predominant among county hospital patients, had risen steadily since 1954.

The survey was based on a sample of 928 residents of the city of Los Angeles who gave birth at Los Angeles County Hospital or at the University of California Los Angeles Hospital as nonpaying patients. It was conducted by public health nurses located at 16 health centers throughout the city. The nurses completed questionnaires in the course of routine postnatal visits to the maternity patients.

The study revealed that 7 out of 10 county hospital maternity patients had received insufficient prenatal attention, and 2 out of 10 had received no prenatal care at all. For the purpose of study prenatal care was defined as "adequate" if the first visit took place in the fourth month of pregnancy or earlier, and if at least five visits to the doctor or clinic had been made. While the city health department had provided some prenatal care to nearly 60 percent of the patients, most of them had sought care late in pregnancy or had made less than 5 visits for prenatal attention. The least amount of care was received by women with Spanish surnames—a reflection, perhaps of the cultural attitudes of Mexican women toward prenatal care.

As in the 1956 study, the proportion of maternity patients under 20 at the county hospital was greater than for the State as a whole. The data also suggested that many mothers who had adequate prenatal care during their first pregnancy did not obtain it during subsequent pregnancies.

The fact that a woman was married and living with her husband seemed to be a significant motivating factor for seeking prenatal care, since mothers who were not with their husbands had on the whole received less prenatal attention. Established Los Angeles residence, though not a requirement for receiving prenatal care in the local health department clinics, seemed to be a factor influencing the receipt of care, since those patients who had been in the county less than a year had had less care than those who had been there longer. Three out of 10 of the women who had received less than adequate care had not reached high school. Patients with high school or college education were apt to have received more care. However, mothers who had had a junior high school education had received less care on the whole than those who had had only elementary education—a finding for which no reason could be determined.

The public health nurses had identified factors that seemed to be the obstacles to adequate care. Among these were the mothers' attitudes: 25 percent of the mothers who had made fewer than 5 prenatal visits for care said they did not feel prenatal care was important; 19 percent had said they did not know about the free clinics. There were also external obstacles: 25 percent cited care of children and 10 percent cited employment as reasons they had not gone for care more often; 34 percent named a variety of other obstacles too vague to be categorized. The nurses who conducted this study expressed the opinion that some reasons for not seeking care cited by the mothers were closer to being rationalizations of their behavior rather than real obstacles which could not have been overcome by greater motivation.

The social worker who carried out the San José study expressed a similar opinion. She believed that if the mothers had thought prenatal care to be really important, the external obstacles to their securing care might have been surmounted. In the San José sample, only 10 percent of the mothers said they understood why care was important.

The report on this Los Angeles study suggests that "no single attack on the problem of inadequate care is likely to yield a solution. An approach on a wide variety of fronts will be required." However, it points out that the high rate of inadequacy of care revealed by the survey indicates "that existing programs and education techniques are not successful in motivating mothers to obtain adequate prenatal care."

The Statewide Study

One of every eight newborns in California is delivered in a county hospital. At the time when the State department of health was first contemplating its statewide survey of the prenatal care received by obstetrical patients in county hospitals, these hospitals were showing prematurity rates that were 50 percent higher that the rates in private hospitals, infant mortality rates that were 60 percent higher, and maternal death rates that were 200 percent higher. The added costs to the counties for the care of premature infants were estimated at $3½ million a year, exclusive of the social costs. These facts were behind the concern which prompted the 1954–56 survey. In this survey an attempt was made to find out something about the quality of care as well as about the quantity of prenatal attention the mothers were receiving.

The data were collected through personal visits by a physician and a social worker from the State health department to every local health department, county hospital, and local welfare department

having a medical care program. Information was obtained from a total of 93 prenatal clinics.

The net result of the study was the documentation of three major unsolved problems: the inadequacy of the quality of prenatal care received by the patients of county hospitals; the obstacle of eligibility requirements for prenatal care; and the failure of many expectant mothers to seek prenatal care.

The actual quantity of prenatal attention which the mothers had received could not be determined since many of the clinics had no such information. However, the county hospitals estimated that 10 to 40 percent of their obstetrical patients had had no prenatal care. The quality of care was also difficult to measure, since at that time there were no State standards for prenatal care. A few minimum criteria were used to measure quality, however, including the number and kind of professional staff present in the prenatal clinics; the amount of time allowed for the doctors and nurses to discuss patients together; the clinical procedures used; and the degree of restrictiveness in eligibility policies.

The survey revealed that clinic physicians spent from 3 to 45 minutes with the patients per visit. Often the patients were seen only by interns, resident physicians, or general practitioners, with little supervision from obstetricians being provided. The clinic nurses spent from 2 to 41 minutes per visit. In some counties, public health nurses also visited each mother at home at least once during the pregnancy. Nutritionists participated in the prenatal program regularly in 5 counties and provided consultation in 18. Social workers—training unspecified—regularly participated in 17 counties and were available as consultants in 9 others.

The procedures for medical examinations, laboratory tests and the like varied among the counties although those regarded by the State staff as most important had been carried out at least once on all patients. Written nursing manuals on clinic policies were available in 15 hospitals and 7 health departments. Special nutritional advice was given in 31 hospitals and 8 health departments.

Rules in regard to eligibility for care varied considerably, and were available in writing in only 60 percent of the agencies having them. Variations in residence requirements were great. Some counties adhered to them strictly and others gave greater attention to the patient's need for care and to the likelihood of the delivery occurring at the county hospital.

Among the disqualifying factors for free prenatal or obstetrical care were: coverage by health insurance; failure to waive the Statute of Limitations in regard to future suits for payment for medical care (2); failure to accept a lien on property (13); seeking care too early or too late (6); being a primipara (5); income over a fixed amount (3); and failure to provide blood for the hospital bank (1). Eligibility factors related to financial need also varied. In 42 percent of the agencies, budgetary standards used were the same as in the aid-to-dependent-children program; 58 percent obtained no prior medical diagnosis before eligibility determination so that complications or other diseases requiring special care were not taken into account.

Followup

The findings of this first overall study of prenatal care in California led the California State Advisory Committee on Maternal and Child Health to make the following recommendations:

1. That the State Department of Public Health . . . develop standards and recommendations for good prenatal care, and provide consultant teams to local agencies seeking to improve their services.

2. That all eligibility policies be written and be made known to all community agencies and professional personnel who serve these families, and that consideration be given to the development of statewide basic policies of eligibility for prenatal care and for hospitalization for complications of pregnancy. Statewide policies are still being worked on.

3. That local health departments find out, if they do not already know, the extent of the deficit in prenatal care in their communities and the reasons why certain mothers either do not seek or do not obtain adequate care, and use the facts to plan appropriate improvement of local prenatal care.

The State health department has already carried out the first of these recommendations with the publication of a booklet entitled "Standards and Recommendations for Public Prenatal Care." [8] The introduction of this booklet points out that these standards while directed to county hospitals and clinics "may also be helpful to physicians in private practice and to staff of non-tax supported prenatal care facilities." They are presented as minimum standards only.

In addition to spelling out approved medical procedures, these standards take into account the social aspects of good prenatal care, emphasizing the family-centered approach to the patient. They included not only a recommendation that a socioeconomic history be part of each medical history, but also a plan for counseling which emphasizes the need to have certain things explained to the expectant mother on her first visit to the doctor. This suggests that as a minimum, "Every expectant

mother needs an opportunity to discuss the effects of her pregnancy on herself and her family." The booklet also describes the functions and responsibilities of each member of the prenatal care staff.

The California State Department of Public Health is continuing to study problems related to prenatal care, especially in relation to prematurity. In order to understand more fully the types of families having premature births as well as to obtain information regarding other types of perinatal loss, the Bureau of Maternal and Child Health is carrying out a project of matching certificates of births and neonatal deaths, a repetition of a study done in 1949. This will provide data on the socioeconomic and demographic factors in relation to prematurity and maternal complications and what changes, if any, have occurred in these data in the past decade.

The department's Bureau of Maternal and Child Health is also considering a study of the characteristics of Negro families having an infant death. This study proposes to include examination of parental knowledge of facilities and attitudes toward use of medical care. Also under consideration is a study comparing prenatal care and hospital care received by patients of the county hospital and a voluntary hospital in Los Angeles.

The Bureau of Maternal and Child Health is also planning a followup statewide survey to determine what, if any, changes there have been in the quality, quantity, or availability of prenatal care since its 1954–56 study, and to determine the impact on prenatal care as a result of its publication of standards.

Another project in Los Angeles is aimed at the improvement of obstetrical records to provide complete information on prenatal, delivery, and postpartum care, and on the newborn. This is being carried out by the Los Angeles city and county health departments and the county hospital. It is hoped that ways will be found of using the newly developed records to facilitate communications between the health department prenatal clinics and the county hospital. The information should also be useful for research purposes, especially in evaluating various types of patient care.

In Los Angeles also, nurses and health educators are experimenting together with different ways of counseling expectant mothers, individually and in groups.

The California studies described here indicate that many expectant mothers do not get sufficient prenatal care. For the most part, they come from the groups of society which are disadvantaged because of discrimination against minorities, low income, lack of vocational skills, poor education, and undesirable living conditions.

These facts underscore the importance of the maternal and child health program in a total public health program and the necessity of keeping such activities from being thrust into the background by the demands of the newer problems of modern "civilization"—air pollution, radiological hazards, the diseases of aging. Health departments must keep a balance in their programs and try to stimulate the raising of standards at every level of responsibility.

The studies also emphasize the importance of considering the psychosocial and cultural factors affecting expectant mothers in planning a program of prenatal care. Only a beginning has been made toward a look at such internal factors as attitudes, knowledge, and the values put on health maintenance. Information about both external and internal factors must be included if a precise picture is to be obtained of the deterrents to prenatal care.

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. . . I trust we all agree that males contribute about 50 percent to the illegitimacy problem.

Arthur L. Johnson, associate professor of sociology, University of Minnesota, to the 1961 forum of the National Conference on Social Welfare.

CHILDREN FROM 1912 TO 2012

As Seen at the Children's Bureau's 50th Anniversary

"TODAY we seek for new ways by which the National Government, the States, the county, and private groups can function together in providing a better life for our children," said the President of the United States, John F. Kennedy, on April 9 in opening the 50th anniversary celebration of the founding of the Children's Bureau.

The all-day celebration was attended by some 950 persons—staff members, former staff members, and friends of the Bureau from all parts of the country—whose work in promoting the health and welfare of children has brought them into close association with the Bureau's activities. It was sponsored by a 55-member committee of parents and professional persons from various parts of the country, with Mrs. John F. Kennedy as honorary chairman, and Melvin A. Glasser, Dean of University Resources, Brandeis University, as chairman.

The celebration had a two-way look, back to the past to appraise the accomplishments for children in the half century of the Bureau's existence and on to the future and what might be anticipated as the needs and goals for children in the 50 years ahead.

The President referred to dramatic reductions in infant and maternal mortality in the last 50 years and to the pioneering efforts made by the Bureau to stimulate the programs which have helped to bring about such reductions. Pointing out that many of the programs that are now taken for granted were once considered daring and new, he suggested that the Bureau's anniversary offered an appropriate occasion to rededicate ourselves to renewed pioneering for the well-being of children and youth.

There are, said the President, still too many young people who are dropping out of school, too many young children left at home by working parents, too many children not getting proper inoculations, too many epileptic children who cannot attend school, too many children of migrant farmworkers whose needs receive little attention. The Government, said the President, has an obligation to assume a "supporting role" to teachers, church leaders, and parents in helping promote a better life for children.

The President also spoke of the need for fundamental reform in services to dependent children, of the need to bring the problem of mental retardation "out in the open," and of the importance of physical exercise in keeping children fit.

Desperate Decisions

Dr. Brock Chisholm, former director general of the World Health Organization, and Jerome Wiesner, special assistant to the President, also spoke at the morning session, both emphasizing the urgency of stemming the drift toward the atomic catastrophe that could prevent children throughout the world from having any future at all.

The next step for the Children's Bureau, suggested Dr. Chisholm, is to see to the consciences of our children. And he implied that the worst thing that could happen to them would be for them to have consciences like our own. Our own conscience values, he pointed out, stem from the world of our ancestors who for security had to be concerned only with the welfare of their own survival group—the family, the clan, the tribe, the State, the Nation, as the course of history enlarged man's circle of interdependence.

But 15 years ago the conditions for survival changed, Dr. Chisholm said, and the survival group quite suddenly became the human race. Yet we still have conscience values based on small survival groups, he maintained, and when we are frightened or anxious "we feel that the right thing to do is to prepare to kill more people" although we now have the power to kill three times more people than there are.

With a similarly grave emphasis, Dr. Wiesner said that the real problem was to get through the next decade or two—"if we can do this I'm not so concerned about the next 50 years." As we move on into the future the discoveries of science are going to confront us increasingly with problems which have to be faced not by the individual but by society, he said, for such discoveries as atomic fission and the control of genetic characteristics cannot be left in the hands of individuals if the world is to survive.

Pointing out that we are the first generation to hold the veto power over the survival of the human race as well as the first generation with the facilities for arranging for its survival, Dr. Chisholm said that we have many barriers to deal with in making our "desperate decisions." These barriers, he said, are in our own personalities, and we can only hope that there is time to bring up a new generation taught to think for themselves and so become free of our traditional ways of reacting.

Science, Dr. Wiesner said, represents a human means of speeding up human evolution, and as the most important cultural influence in modern life must be understood. While it extends human capabilities to a new dimension with almost endless potential, he said, it challenges the human race to the evolutionary choice of cultural adaptation or meeting the fate of the dinosaur. This will require an emphasis on helping children become fuller, richer, members of society and "an almost impossible revolution in our attitude toward education," he maintained.

Contrasts between the needs and resources of children in the developed countries of the West and in underdeveloped countries were presented at the luncheon session by Dan Q. R. Mulock Houwer, Secretary General of the International Union for Child Welfare. (See pp. 91–97.)

Past and Future

The history of the Bureau was reviewed in the afternoon session through a documentary presentation prepared by Mrs. Randolph Guggenheimer and narrated by Ben Grauer of the National Broadcasting Co. The narration was illustrated by slides and the voices of

Katherine B. Oettinger, the Chief of the Bureau, and past chiefs Katharine F. Lenroot and Dr. Martha M. Eliot, speaking for themselves, and of others reading the words of Lillian Wald and Florence Kelley, who first promoted the idea of a Children's Bureau, President William Howard Taft, who signed the congressional act creating it on April 9, 1912, and the first two chiefs, Julia Lathrop and Grace Abbott.

Secretary of Health, Education, and Welfare Abraham A. Ribicoff, speaking at the dinner session, praised the pioneering accomplishments of the Children's Bureau and emphasized the importance of finding new ways to remedy and prevent new social ills. New approaches, he said, are particularly required in meeting the needs of the children in the 995,000 families receiving aid to dependent children, in combating the problems of juvenile delinquency, and in improving educational opportunities.

"Our children are the investment of the future," said the Secretary. "If they need help they must have it. If they can be provided with opportunities, we must assure them these opportunities. To fail to do so is to flirt with fate—both theirs and ours."

Buell Gallagher, President of the City College of New York, also speaking at the dinner, emphasized the importance of marshaling all resources of imagination and inventiveness of all the professions to meet the needs of the whole child. He stressed four problems needing particular attention: Improvement of education and training for potential school dropouts; radical revision of education in the early years to improve reading and speech; urbanization of farm families who move to the city; building up the professions that serve children and youth.

A full report of the anniversary proceedings is being published by the Children's Bureau. Highlights of the Bureau's history are also obtainable in the March–April 1962 issue of CHILDREN, a special issue in recognition of the anniversary.

BOOK NOTES

PREVENTION OF MENTAL DISORDERS IN CHILDREN: initial explorations. Gerald Caplan, editor. Basic Books, Inc., New York. 1961. 425 pp. $8.50.

Twenty-one specialists in mental health—consisting chiefly of psychiatrists, psychologists, and pediatricians—report on research and programs in the United States that are contributing to "some stable underpinning for preventive psychiatry for children." The scope of this collection of papers, delivered at a 1960 conference in preparation for the Fourth International Congress of Child Psychiatry to be held in Holland in 1962, covers various aspects of organic etiologic factors in emotional disorder, including pregnancy complications, the preventive possibilities of professional intervention in personal aud family crises, and the possibilities of preventive work in the "dynamics of teaching."

ADMINISTRATION OF COMMUNITY HEALTH SERVICES. Edited by Eugene A. Confrey. The International City Managers' Association, Chicago, Ill. 1961. 560 pp. $7.50.

Charting guidelines in public health policy and programing, for the benefit of city and county planning and administrative authorities, this volume is the latest in a series of 11 volumes, each on a single aspect of local and municipal administration—with training and reference material—published by the city managers' organization.

The 26 chapters, by administrators and principal aides in community and public health services, outline the essentials of a comprehensive public health program including among other aspects, planning and evaluation, accident prevention and poison control, maternal and child health, health education, nutrition, and health services in disaster.

Prepared in cooperation with the American Public Health Association, the work has copious illustrative material and a bibliography.

EXPERIMENTS IN SURVIVAL. Compiled and edited by Edith Henrich; commentary by Leonard Kriegel. Association for the Aid of Crippled Children, New York. 1961. 199 pp. $3.50.

Thirty-three physically disabled people write about themselves in this book. They communicate their fears, hopes, disappointments, and the problems of learning to function and survive. In short, they tell what it is like to live with a physical handicap.

They are clerks, teachers, students, shopkeepers, whose narratives range from those with narrow focus on the "most crucial of all times—the beginning" to others that illuminate the persistent problems of everyday living. A capsule biography introduces each story and a postscript at the end of the book comments on the importance for the handicapped, the rehabilitation worker, and the public at large to achieve a realistic attitude toward the problems of being physically handicapped—devoid of sentimentality, exploitation, or denial, but with full awareness of the loneliness, pain, and frustration which are the daily diet of the severely handicapped person.

EDUCATING EXPECTANT PARENTS: some observations and recommendations based on a research study. David Mann, Luther E. Woodward, and Nathan Joseph. Visiting Nurse Service of New York, 107 East 70th Street, New York 12. 1961. 224 pp. $4.50.

One of the dominant themes in the authors' observations about classes for expectant parents, based on their 4-year evaluation of those who attended classes given by the Visiting Nurse Service of New York, is this: The course content can be so abstract that these people feel unprepared when faced with the "concrete" issue of baby's crying, refusing to eat, or other displays of negativism. So, the authors advise, instead of teaching what expectant parents say they want to learn—parent educators ought to teach them what "baby" is really like.

HERE AND THERE

Child Refugees

More than 8,000 unaccompanied Cuban children are estimated to have arrived in Miami as refugees from the Castro regime since the end of December 1960, and the influx is continuing at a rate of some 300 a month. Most of these children are adolescents, ranging in age from 12 to 18. Boys outnumber girls, two to one.

A little more than half of these unaccompanied Cuban minors have gone directly to homes of relatives or friends, and the remainder have been placed in children's institutions, boarding schools, and foster family homes in various parts of the country through a program of cooperative voluntary-public effort involving the Federal Government, the Florida State Department of Public Welfare, other State welfare departments, several national voluntary agencies, local child-caring agencies in Miami and vicinity and in other communities where the children have been placed. The national voluntary agencies especially concerned with this program are the National Catholic Welfare Conference, Church World Service, United Hebrew Immigrant Aid Society, and the International Rescue Committee.

The Florida State Department of Public Welfare is serving as the agent of the Department of Health, Education, and Welfare in administering the Federal Government's program for aid to Cuban refugees. (See CHILDREN, May–June 1961, page 116.) As a part of this program the Federal Government pays for foster care for these children on a per diem basis from the child-caring agencies. All arrangements for meeting the children at the Miami airport, for their temporary care before placement, and for selecting the agencies or institutions which will provide care for these children are made by the voluntary agencies. Children have been placed in 67 cities in some 30 States. Besides Miami, cities which have received more than 50 children for placement include: Helena, Mont.; New York, N.Y.; Reno, Nev.; St. Augustine, Fla.; Toledo, Ohio; and Wichita, Kans.

Since 95 percent of the children coming from Cuba are Catholic and nearly all the children in the program arrive in this country at Miami, the main burden of placement has fallen to the Catholic Welfare Bureau of the Diocese of Miami. This agency has arranged for the temporary shelter of nearly 3,000 children in Miami and has placed about 950 children in institutions and foster family homes in Miami and the rest of Dade County. It has also arranged with child-caring agencies elsewhere for the acceptance of Cuban children. To carry out this program the Catholic Welfare Bureau has set up a new unit and five transient centers, the new unit operating separately from the agency's regular child-care program which is supported by the Miami United Fund. The unit for Cuban children has a staff of 325 workers including 21 Spanish speaking priests and members of religious orders, the majority refugees themselves.

Other Miami agencies which have received Cuban children are the Jewish Family and Children's Service and the Children's Service Bureau, a nonsectarian agency.

Since the Federal program of assistance for unaccompanied Cuban refugee children was started, some 4,000 children have been given foster care for varying periods of time. Approximately 1,300 children have already rejoined their parents in the United States or have gone to live with relatives or close family friends. As of January 31, 1962, there were 1,923 in institutional care and 527 in foster family care.

Human Rights

"If Congress takes no further action on this matter next year, I will implement my decision that segregated education off base for children living on Federal property is unsuitable and will proceed under the authority given me in the statutes [Public Law 815, September 23, 1950, as amended, and Public Law 874, September 30, 1950, as amended] and will proceed to provide nonsegregated education for these children," said the Secretary of Health, Education, and Welfare Abraham A. Ribicoff, on March 30, 1962. With the implementation of this decision no child living on Federal property will be required to go to a segregated school after September 1963.

The Federal statute for school assistance in federally affected areas, to which the Secretary referred, provides assistance for the construction of school facilities and for operation of schools for those school districts overburdened with children who live on Federal property or who live with a parent employed on Federal property. Payments are made on a per child basis under a formula written into the law.

. . .

The possibility that the Federal Government may unwittingly be playing a role in the maintenance of patterns of racial segregation was examined at the February meeting of the Interdepartmental Committee on Children and Youth. William L. Taylor, director of the Division of Liaison and Information of the U.S. Commission on Civil Rights presented some of the findings in this regard included in the Commission's five-volume 1961 report. He asserted that while the Federal Government is not directly implicated in segregation, yet, by maintaining a policy of "neutrality" in various of its grant programs related to education, housing, health, and employment, in many instances it was subsidizing discriminatory programs.

In addition to school construction and maintenance in federally affected areas, Federal money through loans and mortgage guarantees is a major force in the expansion of housing and home finance industries, as well as in hospital construction, vocational training, and other grant-in-aid programs where discriminatory practices persist, Mr. Taylor reported.

Mr. Taylor reported that the Commission had made two types of recommendations in this regard: (1) the conditioning of Federal funds to the assurance of nondiscrimination in their use; and (2) affirmative programs of Federal financial support to programs which emphasize action to overcome discrimination.

The five volumes of the Commission's report are: "Voting" ($1.25); "Education" ($1); "Employment" ($1);

"Housing" ($1); "Justice" ($1). They are for sale by the Superintendent of Documents, Government Printing Office, Washington 25, D.C. A sixth volume, "Civil Rights," includes excerpts from the other five volumes. It is also available, for 45 cents, from the Superintendent of Documents.

Child Welfare

Prompted by reports of apparent increases of the numbers of infants and young children who have been subjected to physical abuse, the Children's Bureau held an all-day conference in Washington in mid-January to discuss ways the Bureau might help States and communities combat the problem. At the conference, which was attended by 25 pediatricians, judges, lawyers, social workers, and other specialists from various parts of the country, numerous incidences were cited of evidence of past injuries being discovered in children brought to hospitals for treatment of an "accidental" injury.

The discussion focused on the complexity of the problem, particularly in determining whether or not abuse actually exists and in taking action to protect the child from further abuse. Because of the difficulty of diagnosis when parents or other caretakers have been involved as well as because of the confidentiality of information relating to their patients, physicians are often reluctant to report suspected abuse to the courts, it was reported. Treatment of the problem, it was agreed, requires the concerted efforts of medical, legal, and social workers.

Among the proposals for Children's Bureau action were the dissemination of information to the various professions dealing with children and the further exploration of the need for legislation.

. . .

By March 1, the deadline for applying for funds under the new Children's Bureau program of research and demonstration grants in child welfare, 63 applications had been received.

The program, authorized by the 86th Congress in 1960, will support demonstration and research projects of national or regional significance and those demonstrating new methods or facilities with promise of contributing to the advancement of the child welfare field. The grants may be made to public or nonprofit institutions of higher learning or public or nonprofit bodies engaged in child welfare research.

Forty-two of the applications fell within the present priorities of the Children's Bureau—social services provided by public and voluntary child welfare agencies, and research that showed promise of contributing to the advancement of these services.

Among the applications were proposals for projects for mentally retarded children, new uses for day-care services—such as raising the cultural level of children and their families that have been culturally deprived—and for homemaker services, study of adoption of foreign children by American parents, followup of older children and their adoptive parents, and demonstrations of social group work for parents and children with special needs and of counseling teenage married couples. Recommendations on grants will be made to the Chief of the Bureau by a nine-member advisory group, meeting on May 15, 1962.

June 1 is the deadline for new applications to be acted on in the fall of 1962.

Mental Retardation

Some 400,000 newborn infants with be screened for phenylketonuria during a year starting July 1, 1962, in a national program spearheaded by the Children's Bureau, to help ward off mental retardation resulting from this disease. With the cooperation of selected hospitals and State health departments, the program will apply the new Guthrie Test, which reportedly can detect babies with phenylketonuria during the first few days of life. A special diet can then be set up to control the disease and prevent mental retardation.

The new test, using a few drops of blood from the baby's heel, was developed by Dr. Robert Guthrie of the University of Buffalo. It has been used in screening more than 3,000 persons for phenylketonuria in New York. Until now, the most widely used test was the ferric chloride, or diaper, test of urine, which cannot be used effectively until several weeks after birth.

If the testing procedures prove widely applicable, they will be extended to programs for other inborn metabolic errors.

. . .

The Hawthorn-Northville Chapter of the Michigan Association for Retarded Children recently purchased a bus for the Children's Service of the Northville State Hospital with the use of trading stamps gathered in a campaign that brought in stamps from all over the State and beyond. The bus will be used to take children to classes at a specialized treatment facility for emotionally disturbed children several miles away.

Nutrition Conference

Some 300 educators, nutritionists, and physicians attended a Nutrition Education Conference in Washington, D.C., the last 3 days of January 1962. The fourth such national conference held since 1941, the meeting was sponsored by the Agricultural Research Service of the U.S. Department of Agriculture and the Interagency Committee on Nutrition Education which is representative of the U.S. Departments of Agriculture, Interior, State, and Health, Education, and Welfare; the American National Red Cross; and the North American Regional Office of the United Nations Food and Agriculture Organization.

In contrast to the 1941 conference, which concentrated chiefly on malnutrition, the conference this year emphasized the social and emotional aspects of food, overnutrition, and obesity. With the theme, "Improving Education for Children," it examined the contributing factors to poor food habits among young people, the possibility of coordinated and comprehensive educational programs to help children achieve and maintain good food habits; and the contribution the conference participants might make to such programs.

The general consensus seemed to be that the diets and nutritional status of children as a whole in this country are today better than ever before in the Nation's history, but that there are still areas of needed improvement. Among the examples of the latter cited were: a lack of calcium and vitamins C and A in some children's diets; a tendency for many teenage girls to decrease their food intake at a time when their need for food increases; a tendency toward overweight among relatively inactive children, encouraged by the ready availability of a variety of food with high sugar content—as in vending machines—and by the high level of purchasing power among children today.

The participants repeatedly urged the application of current scientific knowledge of the behavior patterns of

children and teenagers in an effort to improve food habits. The importance of recognizing the varying nutritional needs of children in various stages of growth and states of health was also stressed, as was the importance of helping children to acquire good food habits early through nutrition education for the parents.

Pointing out the relation of good nutrition to physical fitness, Ruth M. Leverton, assistant administrator of the Agricultural Research Service, suggested that "when our children and youth see physical fitness, including nutritional well-being, related to what they want to do and what they want to be, they will be eager for the information and training that will help them develop good habits of activity and food selection."

Services in Housing

A joint effort to promote services related to health, education, and welfare in public housing projects was initiated in mid-March by the Secretary of Health, Education, and Welfare, Abraham A. Ribicoff, and the Administrator of the Housing and Home Finance Agency, Robert C. Weaver. To implement the program, a 22-member task force representative of various units of the Department and the housing agency has been formed, charged with studying the needs of tenants in low-income housing projects, developing projects toward meeting these needs, and recommending to the Department and the Agency measures to improve services to persons living in public housing.

The task force is directed by Wilbur J. Cohen, Assistant Secretary of Health, Education, and Welfare, and Marie McGuire, Commissioner of the Public Housing Administration. Co-chairmen of the group are Abner Silverman of the Public Housing Administration and Alvin L. Schorr of the Social Security Administration. An advisory panel composed of experts in the variety of services needed by low-income families in urban settings has been appointed to work with the group.

While many of the needed services may be available for residents of low-income housing projects, frequently they are distant from the project or the residents are unaware of them. The task force is undertaking the dual assignment of identifying all of the appropriate services provided through programs of the Department and negotiating with State and local agencies and housing authorities for one or more demonstration projects in which a concentration of services can be made available simultaneously within or near the project site, plus information about them to the project residents.

Such services may include those concerned with aid to the aging, the prevention of juvenile delinquency, job training, day care of children, health, rehabilitation for the disabled, and money management and housekeeping.

Vital Statistics

According to the Public Health Service, a total of 4,257,850 live births were registered in the 50 States during 1960, or 4,000 fewer than in 1959, continuing a 4-year downward trend in the birth rate (23.7 per 1,000 live births as compared with 25 in 1957).

Although 700,000 more babies were born in 1960 than in 1950, the birth rates for the 2 years are almost the same. Named as a contributing factor in this static rate is the 5-percent decline in birth rates during the decade in the South, where the rates traditionally have been high—a drop not offset by higher rates elsewhere.

Alaska reported 33.4 live births per 1,000 population in 1960, the highest figure for any State, while the lowest rate was recorded for West Virginia, with 21.2. The relative position of these States in 1950 was fourth and twenty-second, respectively. Such changes in States' birth rates, the Service attributes to such causes as the immigration of young adults of childbearing ages; the postponement of births in areas of high unemployment; and the effects of previous high birth rates on the population's age composition.

The year 1961 is estimated to have appreciably more births registered than during 1960, but not enough to change the downward trend in the rate.

. . .

Since 1954, the infant mortality rate among American Indians of the United States, except Alaska, dropped 30 percent in 6 years—from 65.5 per 1,000 registered live births to an estimated 46 per 1,000 in 1960. The infant mortality rate for the Nation as a whole was 26.4 per 1,000 live births for 1959 and the provisional rate for 1960 was 25.7. Among Indian babies aged 28 days through 11 months, the fall in the death rate was 41 percent in the period 1954 through 1959. Only about 21 percent of all Indian deaths reported for 1959 were of babies under a year of age compared with 27 percent in 1954.

For Health

Field trials of two types of measles vaccine, of killed virus vaccine alone, and of killed and live virus vaccines in combination, were begun in mid-December 1961, among 5,000 children in five parts of the country—the first large-scale tests of this nature. In cooperation with the Communicable Disease Center of the Public Health Service, local health departments are conducting the trials in Dekalb County, Ga.; Cincinnati, Ohio; Seattle, Wash.; and in Rochester and Buffalo, N.Y. Previous trials of measles vaccine tested the live vaccine alone, frequently producing fever or rash; and the live vaccine used with gamma globulin, supplies of which may be inadequate for mass vaccinations. (See "For Health," CHILDREN, Jan.–Feb. 1962, page 34.)

In the current study, children are being divided into three groups: those receiving three shots of killed virus vaccine; those receiving two shots of killed vaccine and one of live; and those receiving dummy injections.

. . .

Late in 1961, the Public Health Service began a survey of professional but inactive nurses who maintain State registration in order to determine how many of the country's estimated pool of 200,000 such nurses can be called on to return to full or part-time work and under what conditions. The survey results will be made available to communities for use in program planning or expansion.

The first group of questionnaires was sent to inactive nurses in the States of Alabama, Georgia, Kansas, Mississippi, North Carolina, and Vermont, with the cooperation of the State boards of nurse examiners and State nurses associations.

. . .

A new program to promote the application of research knowledge in the field of neurological and sensory disorders has been set up by the Public Health Service. As the Neurological and Sensory Disease Service Program, the new unit will stimulate, develop, and support activities concerned with prevention, diagnosis, and treatment

of such disorders as epilepsy, cerebral palsy, multiple sclerosis, mental retardation, and some types of vision, speech, and hearing defects; and with the rehabilitation of persons affected by these conditions.

The program, administered by the Bureau of State Services, will provide consultation, technical services, demonstrations, training, and health education to communities directly and through grants, in cooperation with State health agencies, medical schools, professional organizations, and other private and public nonprofit groups.

. . .

A task force appointed by the Public Health Service has charted a six-pronged campaign against infectious syphilis, based on findings that show a rise of more than 130 percent in cases of this disease among teenagers between 1956 and 1960. The study group's plan calls for spending $3½ million annually for 10 years over funds currently available to the Service for direct operations and grants to the States for venereal disease control. The recommended steps were these:

- An intensive national effort providing for at least two visits a year by a specialist in venereal disease to the general practitioners across the country and one visit a year to other physicians to help alert doctors to the symptoms of syphilis in their patients.
- A program to insure that all blood processing laboratories report to health departments all specimens with positive reactions to syphilis along with the names of the patients.
- More research in syphilis immunology, therapy, and laboratory procedures and on adolescent and young-adult behavior.
- The broadening of interview investigation services toward covering all infectious syphilis cases.
- A broad education program for professional workers and the general public.
- Continued support of the program by Federal, State, and local governments even after the reported number of cases begins to decline.

Considered particularly disturbing was evidence that syphilis is being spread unknowingly, especially among teenagers. The task force noted the need for further efforts to bring private physicians into the control effort. The members estimated that such physicians now report slightly more than one-half of the syphilis cases they diagnose and treat, compared with only about 25 percent in the 1955–58 period.

The 18,781 cases of syphilis reported for the fiscal year 1961 was the highest total since 1950.

Health Research

With the goal of finding out more about the relationship between virus infection in expectant mothers and neurological disorders—such as cerebral palsy, Mongolism, and mental retardation—in newborn infants, a study involving more than 75,000 pregnant women has been launched by the National Institute of Neurological Diseases and Blindness and the National Institute of Allergy and Infectious Diseases, Public Health Service.

Blood samples collected from expectant mothers at 16 collaborating medical centers throughout the Nation are being tested at the Institutes for evidence of exposure to more than 100 viruses, ranging in severity from common cold viruses to those causing paralysis and death. The tests make use of antigens—substances that stimulate a chemical defense mechanism in the blood. Together with data on the patient's pregnancy, information on her serum sample is to be retained for years.

The study is a phase of a broad NINDB project, started 5½ years ago, in which mothers-to-be are examined from early pregnancy through labor and delivery, and their babies followed up from birth through school age. One goal of the study is to widen understanding of the processes of conception, pregnancy, labor, and delivery as related to growth and development of the child. Another aim is the collection and analysis of data on factors possibly related to disorders of infancy and childhood.

Mental Health

A conference in followup of the report of the Joint Commission on Mental Illness and Health—released in April 1961 under the title, "Action for Mental Health" (Basic Books, New York)—was held March 5–7, 1962, in Washington, D.C., under the sponsorship of the National Association for Mental Health in cooperation with more than a hundred national social, health, civic, and professional organizations.

In the report, the Commission—formed through Congressional action in 1955, of representatives of 36 national organizations—distills the fruit of 6 years of factfinding on the needs and care of the mentally ill and charts lines of action for a national mental health program. Considering the current lag in treatment of the mentally ill as reflecting a basic pattern of social rejection, the report underlines the need for more public understanding of mental health problems and more cooperation between all types of organizations at all levels in developing mental health programs.

Gathering in five study groups, the more than 200 participants focused their discussions on mental health program development from the vantage points of communities and of national organizations, developing such lines of emphasis as these:

- Like any other work in human welfare, the mental health program that does not start with the individual, does not start; and if it ends with him, it ends indeed.
- Education of the public cannot be achieved in a vacuum, but rather through demonstration and confrontation, for example, through the cumulative effect in time, of recruiting an army of volunteer workers when they are young.
- The volunteer can be interpreter between community and patient and link between him and employer.
- We must look for what it is in our society that, although producing fine service programs and dedicated volunteer workers, engenders broken homes, delinquency, and mental illness.

. . .

A research project designed to help strengthen lines of communication and coordination between nursery education and the mental health disciplines has recently been initiated by the Child Development Center of New York, a voluntary clinic with a nursery school which concentrates on the study and treatment of emotionally disturbed children. Under the project a team of nursery educators, social workers, pediatricians, psychologists, and psychiatrists will seek to unify their efforts. Its director is Peter B. Neubauer, M.D.

An early step in the 5-year project will be the cooperative development of criteria for evaluating child develop-

ment. Another will be the determination of what function each discipline has in fostering healthy growth and in detecting and helping the disturbed child.

The project, estimated to cost about $300,000, is being underwritten by the Grant Foundation.

Unmarried Mothers

Broadening the scope of services at child health stations in low-income neighborhoods of New York City to include direct social services to mothers, was foremost among recommendations emerging from a recently reported study of the socioeconomic and medical problems facing young, unmarried mothers registered at such stations in the Central and East Harlem Districts.

Conducted in 1960 by Dr. Nina Bleiberg and three associates from the city's department of health, the study provided a questionnaire that was used by 25 doctors at 10 health stations in interviews with 300 primapara mothers under 22 years of age. Of this group, 116 were unmarried; 80 percent were Negro and 20 percent, Puerto Rican. Among the 206 teenage mothers in the total group, 43 percent were unmarried when interviewed.

The findings indicated that the unmarried mothers were generally inarticulate about expressing their social or emotional problems, but a large majority reported having had concern about social stigma during pregnancy.

The study was used to enrich the educational program for the conference medical staff; one of its recommendations called for broadening this program for medical personnel, so as to stress the presence of socioeconomic and emotional elements within the total health spectrum.

. . .

The Research Division of the Children's Bureau in early February began a review of research and demonstrations relating to unmarried mothers and their children. Directed by the Chief of the Child Life Studies Branch, the review team includes a sociologist and a social caseworker. The purpose is to discover how much tested information we have about unmarried mothers and their children, and about the effectiveness of efforts to help them.

The results of the study, scheduled to end in late June, are expected to furnish the bases for: charting needs and setting up priorities in research and demonstration projects; decisions concerning services, programs, and community efforts; and various publications for lay and professional readers.

Correction

Elizabeth G. Meier, lecturer at the New York School of Social Work, Columbia University, previously was district supervisor with the Division of Child Welfare, State Department of Health and Welfare in Maine and worked in child welfare in Michigan, Connecticut, and New York. She did not serve as district child welfare supervisor in Michigan, Connecticut, and New York, as reported in the biographical note that appeared in the January-February 1962 issue of CHILDREN in connection with her article, "Focused Treatment for Children at Home."

Films on Child Life

Films listed here have been reviewed by staff members of the Children's Bureau. The listing does not constitute endorsement of a film, but indicates that its contents have merit. Charges for rental or purchase, not given because they change, may be obtained from distributors.

SKIPPY AND THE FOURTH R. 24 minutes; sound; black and white or color; purchase or rent.

Portrays the family and church working together to help a second grader to understand the value of honesty in family relationships.

Audience: Parents, teachers, parent education groups related to the church.

Produced by: Jarvis Couillard for the Methodist Television, Radio, and Film Commission.

Distributed by: The Methodist Television, Radio, and Film Commission, 1525 McGavock Street, Nashville, Tenn.

AUDITORY SCREENING FOR INFANTS. 15 minutes; sound; color; purchase or rent.

Shows reactions of infants who are 8 to 10 months old to sound stimuli, in order to encourage the use of the auditory screening technique as part of the routine physical examination of every infant by the time he is 8 or 9 months old.

Audience: Physicians; nurses; speech and hearing specialists; medical and nursing schools; schools of public health; and speech and hearing centers.

Produced by: Child Growth and Development Study, The Johns Hopkins University and the Division of Maternal and Child Health, Maryland State Department of Health.

Distributed by: The Bureau of Preventive Medicine, Maryland State Department of Health, 301 West Preston Street, Baltimore 1.

THE WELL CHILD CONFERENCE. 14 minutes; sound; color; purchase.

Shows how doctors, nurses, volunteers, and parents can work together to provide health supervision for babies and young children at a well child conference.

Audience: Professional health workers; students; parents.

Produced by: Kent Lane Films for the Kentucky State Department of Health.

Distributed by: Kent Lane Films, care of George W. Colburn Laboratories, 164 North Wacker Drive, Chicago 6, Ill.

A NEW WORLD FOR PETER. 22 minutes; sound; purchase or rent.

Tells in a child's own words about his trip to the hospital, his operation, and the people who helped make him safe and comfortable.

Audience: Parents, teachers, elementary school children or discussion leader: social worker, nurse, or dietitian from the community who is familiar with local hospital practices.

Produced by: Kay Hanna for the Parents' Committee of the Children's Ward of Tompkins County Hospital, Ithaca, N.Y.

Distributed by: A New World for Peter, Post Office Box 23, Ithaca, N.Y.

READERS' EXCHANGE

BAUMGARTNER: *Parent education needed*

I read with great interest Dr. Leona Baumgartner's article, "A Fresh Look at Child Health." [CHILDREN, March–April 1962.] It is encouraging to be reminded of the progress made in less than 50 years, particularly as the progress is continuing, and it is timely to emphasize that dollars alone do not achieve the goals though they may ease the task if properly utilized. Repeated review and re-evaluation of the problems as well as the facilities and personnel available are essential to maintain progress at the highest rate.

The specialization mentioned by Dr. Baumgartner is not limited to the field of medicine. It has occurred in the fields of social work, welfare, and in education. In fact, I believe that here and there I see physicians broadening their focus to include not only the "whole" individual, but also his social and economic environment. Increasingly the health problems are being met by the team-play Dr. Baumgartner has mentioned. Specialization will continue and should be encouraged to a certain extent. After all it is the result of recognition of a problem and research into the causes and treatment.

The most obvious difficulty in relation to medical education is the mass of material to be studied, evaluated, and appropriately utilized in the continuing education of the physician. Not recognized by many is the impossibility of teaching experience. Experience can only be achieved and sometimes painfully. The controversy in medical education is a healthy one and as long as it exists we are not in danger of becoming stereotyped in our thinking and in educational methods. When one talks to a group of medical students any worry about becoming stereotyped is alleviated. Their attitudes vary in direction and intensity with a high percentage showing a healthy scepticism. We try to give them a good basic knowledge and a determination to learn more.

One area of education and training Dr. Baumgartner did not discuss is much more difficult to teach than medicine: how to teach people to be parents. We can teach parents only general principles which must be interpreted for each individual. Even a knowledge of principles does not mean parents can apply them in the pressure of all the duties, stresses, fears, and confusion with which they must contend, even under the best of circumstances. Some of the labor-saving devices mentioned by Dr. Baumgartner may give more time for this type of education.

Philip S. Barba, M.D.
Philadelphia

ADAMS: *Defense of study*

Because of my involvement in one of the studies described in Hannah Adams' article entitled "Two Studies of Unmarried Mothers in New York City" [CHILDREN, September-October 1961], I feel compelled to take exception to a statement of Charles E. Bowerman in his comments on the article. ["Readers' Exchange, CHILDREN, January-February 1962, pages 39–40.] Prof. Bowerman says "It is likely that much, if not all, of the differences found between married and unmarried mothers with respect to amount and type of prenatal care, infant mortality, and so on, would have disappeared if the data had been controlled for socioeconomic status, broken-home background, and other variables which might be considered as more basic than the marital status of the mother."

The study of the Community Council of Greater New York, and the study representing a joint project of the health and welfare departments indicate that the differences in the prenatal medical care records of married and unmarried women are greater than could be attributed to socioeconomic differences alone. In the Council's study of deterrents to prenatal care and social services, we point out that "the differences in the timing and regularity of prenatal medical care among the unmarried mothers of various age, ethnic, or religious groups, or education, are not nearly as marked as the difference between all unwed expectant mothers and married expectant mothers."

Although our study indicates that the unwed mothers who have attended college have a better record of prenatal care than those who have not, this difference is small. The analysis of prenatal care in relation to occupation shows that there is little difference in the pattern followed by private household workers on the one hand and women in clerical and kindred occupations on the other. It shows further that operatives and kindred workers have a slightly better record of prenatal medical care than either the private household workers or the clericals. Thus we concluded that except for some of the women who had had some college education, neither education nor occupation appear to be related significantly to the timing and regularity of prenatal care among unwed mothers.

Furthermore, the fact is that the proportion of white unwed mothers who had no medical care at all during the first 6 months of pregnancy was somewhat larger than the proportions of either the Negro or Puerto Rican mothers. Relatively more of the white women had attended college. Relatively fewer of the white women were receiving any form of public assistance and relatively more of the white women were supported, at least in part, by their relatives. It would appear that the urge to conceal the pregnancy, found as a major deterrent to early and regular care of white unwed mothers, counterbalances any influence of socioeconomic status on their use of medical services.

Mignon Sauber
Director of Research, Community Council of Greater New York

BLAKE: *Example in St. Louis*

It was with much interest that I read Howard Leary's comments on Mary Blake's article in relation to the need for a bible to be put in the hands of youth workers and police working together. [CHILDREN, "Readers' Exchange," January–February 1962, page 39; and "Youth Workers and the Police," September–October 1961.]

In St. Louis we have a plan of close cooperation which has been developed by the city of St. Louis police department and the Youth Project of the Met-

ropolitan Youth Commission, a research and demonstration project on how to work with street-corner youth. The difficult experiences in other cities prompted the commission to develop with our local police department a guide for interagency relationships. Our Commission is very fortunate in having an extremely cooperative, serious, and professionally minded police department interested in a coordinated approach with social agencies in efforts to prevent and control delinquency. Individual copies of the guide have been distributed to all police officers in the district served by the Youth Project.

In St. Louis, our youth workers work with groups only as a means of contact. They aim neither to strengthen the group nor weaken it but to determine the composition of its members, their relationship to each other, and how the group or subgroups within it can be used to keep social behavior under control. There is a misconception on the part of many in various disciplines that group workers are out to organize groups, then lead them as groups. This is a fallacy.

The youth groups our workers are in contact with are for the most part very fluid. The function of the group worker is to see that their members are channeled into social behavior either on an individual or a group basis.

Eugene P. Schwartz
Executive Director, Metropolitan Youth Commission of St. Louis and St. Louis County

Guides and Reports

MENTAL RETARDATION AND SOCIAL WORK EDUCATION: proceedings of a conference held at Haven Hill Lodge, Milford, Mich., June 16–19, 1959. Edited by Alfred H. Katz. Wayne State University Press, Detroit. 1961. 56 pp. $1.50.

From a conference sponsored by the American Association on Mental Deficiency and the Council on Social Work Education, this pamphlet includes a conference position paper setting forth the responsibility of social work education in the field of mental retardation and stressing the need for a basic understanding among social workers of mental retardation and the importance of the multidisciplinary approach; and three papers discussing: mental retardation as a social problem; social work services to the retarded; and social work education for services to the retarded. Summaries of the discussions are also included.

THE SPECIAL CHILD: diagnosis, treatment, habilitation. Harold Michal-Smith, Shulamith Kasten, and others. New School for the Special Child, Bureau of Publications, 71 Columbia Street, Seattle 4, Wash. 1962. 350 pp. $5.50.

Converging on the problem of training the children having brain injuries, neurological impairments, or functional retardation, from the vantage points of several professions—psychologist, speech pathologist, psychiatrist, and teacher—18 papers in this collection focus successively on mental retardation, brain injury, cerebral palsy, communication disorders, and "nervous habits." They are based on lectures delivered at a 1960 conference in Seattle sponsored by the University of Washington and the New School for the Special Child.

THE HANDICAPPED CHILDREN OF FORT WORTH AND TARRANT COUNTY; a study of community services for handicapped children. Tarrant County Community Council, Life of America Bldg., Fort Worth, Tex. 1961. 106 pp. $1.12.

A report of a study made by a consultant team of three physicians to determine the basic and special needs of physically handicapped children in the area of Fort Worth, Tex. The study was made under the auspices of the Community Council of Fort Worth and Tarrant County, in cooperation with the Texas State Department of Health and the regional medical staff of the Children's Bureau, Department of Health, Education, and Welfare.

WHEN CHILDREN NEED SPECIAL HELP WITH EMOTIONAL PROBLEMS. Greta Mayer and Mary Hoover. Child Study Association of America, 9 East 89th Street, New York 28. 1961. 30 pp. 40 cents. Quantity rates available upon request.

Written for parents and professional persons engaged in services to children, this pamphlet discusses: symptoms of chronically disturbed behavior in children from birth through 17 years; types of treatment available; the professionals engaged in treatment; and the cost and length of treatment.

PHASES OF ADJUSTMENT IN A TYPICAL FOSTER HOME PLACEMENT. Erika Juliusburger. Jewish Child Care Association of New York, 345 Madison Avenue, New York 17. 1961. 20 pp. 75 cents.

A condensation of an original paper given at the 1960 Eastern Regional Conference of the Child Welfare League of America, this report presents the experiences of a 12-year-old girl who for 4½ years lived in the same foster home, describing the phases of adjustment inherent in this type of long-term placement.

PREVENTION - TREATMENT - CONTROL OF JUVENILE DELINQUENCY THROUGH GROUP WORK SERVICES: proceedings of the annual spring conference of the Inservice Training Department, New York City Youth Board. May 1959. New York. 1961. 83 pp. Free.

The conference discussions are abstracted under workshop topics: programing for teenagers; finding the individual in the group; confidentiality and other principles in client-worker relationships; the growing pains of adolescence; and "changing means in changing scenes." The chief concerns to emerge are presented in a summary as community changes, effect of changes on attitudes of youth, and what group workers and agencies can do.

SOME U.S. GOVERNMENT PUBLICATIONS FOR PROFESSIONAL WORKERS

Publications for which prices are quoted are for sale by the Superintendent of Documents, U.S. Government Printing Office, Washington 25, D.C. Orders should be accompanied by payment. Twenty-five percent discount on quantities of 100 or more.

HEALTH SERVICES FOR MENTALLY RETARDED CHILDREN: a progress report, 1956–60. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. 1961. 34 pp. 30 cents.

After tracing the development of the Bureau's health services to mentally retarded children, the publication reviews the program's achievements, special demonstration projects, and the work of the Bureau's technical committee on clinical programs. It then projects the future extent and composition of the mental retardation problem, suggesting adaptations of State and local special services and overall program goals.

IMPLICATIONS FOR ELEMENTARY EDUCATION: followup on the 1960 White House Conference on Children and Youth. Office of Education, Department of Health, Education, and Welfare. 1961. 25 cents.

This pamphlet is organized into four sections: (1) "Important Commitments," presenting eight recommendations as an "honor roll of priorities;" (2) "The Good Elementary School," presenting the attributes, curriculum emphasis, general atmosphere, and organization of such a school; (3) "The Operating Context of the School" related to national, community, and family interests; (4) an appendix, presenting an index to the recommendations on education of the 1960 White House Conference on Children and Youth, and recommendations from the 1955 White House Conference on Education.

TRAINING FOR SERVICE IN PUBLIC ASSISTANCE: papers presented at the 1960 seminars for field representatives conducted by the Bureau of Public Assistance, Washington, D.C. Department of Health, Education, and Welfare, Social Security Administration, Bureau of Public Assistance. 1961. 251 pp. $1.

A selection of 14 papers prepared for State field representatives working in the Federal-State public assistance program to help them develop local programs and provide leadership and direction to local welfare agencies. Among the subjects dealt with are policy development, community coordination and planning, administrative methods, interfamily relationships, the needs of working mothers and their children, and implications of the choice to work for mothers in the aid-to-dependent-children program.

DAY CARE SERVICES: form and substance; a report of a conference, November 17–18, 1960. Gertrude L. Hoffman. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. CB Publication No. 393. 1961. 55 pp. 25 cents.

This is the full report of a conference sponsored by the Children's Bureau and the Women's Bureau of the Department of Labor, in Washington, D.C., and reported briefly in the January–February 1961 issue of CHILDREN [page 35]. Summaries of papers presented at an opening symposium and of the 12 group discussions on the various elements essential to a good community program are followed by the conference recommendations.

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JULY • AUGUST 1962

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Youth's Need for Challenge

Order in the Court

Teenagers and Venereal Disease

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N - HIGH

AN INTERDISCIPLINARY JOURNAL FOR THE PROFESSIONS SERVING CHILDREN

children

VOLUME 9
NUMBER 4
JULY–AUGUST 1962

BLARING AWAY on their trumpets, the members of this high school band have a chance not only to blow off excess energy but also to attain the satisfaction of participating in an activity which calls for cooperation and competence.

Providing young people with opportunities for building up self-esteem through a sense of competence is one of the first obligations of adults and of adult institutions which are concerned with youth, according to the lead article in this issue.

A member of the National Committee for Children and Youth, Roy Sorenson has had 40 years of experience in work with young people. Beginning as boy's work secretary in the Milwaukee YMCA, and later serving for 19 years in various capacities on the staff of the National Council of YMCA's, he went to his present position in 1946. He is chairman of the California Governor's Commission on Metropolitan Problems and a trustee of the Rosenberg Foundation.

After graduating from the University of Michigan Law School, William T. Downs went into the private practice of law and later became a judge of probate with juvenile court jurisdiction. In his present position with the State supreme court, he is assigned to probate and juvenile courts. He is on the Michigan Youth Commission.

A shift in careers during the depression of the thirties, from foreign language teaching to social work, led Celia S. Deschin first into family casework in New York, then into teaching in schools of social work here and in Canada, in welfare agencies, and in medical schools, and eventually into research. With her master's from the New York School of Social Work and her doctorate from New York University, she is now directing a study of suburban life.

With a master's degree in social work from the University of Missouri, Alice Hornecker supervises the field-work of students from the university's school of social work. She was a child welfare worker in a local public welfare department before assuming her present position with the State welfare department in 1956. Prior to going into social work, she taught in elementary and secondary schools in rural areas.

A graduate of Vanderbilt School of Nursing and of the Harvard School of Public Health, Dorothy E. Johnson has been teaching pediatric nursing for nearly 20 years. After 5 years on the faculty of Vanderbilt, broken by a year's interlude on the staff of a local health council in Georgia, she joined the faculty of the University of California at Los Angeles. In 1955, she took a year's leave to go to India with an ICA mission as an adviser on pediatric nursing.

Elizabeth Herzog joined the Children's Bureau in 1954. Her previous experience had included research in social work, studies in cultural anthropology, and conduct of opinion and attitude studies for the Office of War Information. Among her many publications are a number concerned with the application of research methods to social work and social problems.

◀ *the authors*

YOUTH'S NEED FOR CHALLENGE AND PLACE IN SOCIETY

ROY SORENSON

General Secretary, YMCA of San Francisco

TODAY adolescents are having to find fulfillment of their development needs in a brand new kind of society. For this there are no road maps. This is why it is so hard for adults to understand and so easy to misunderstand. We misunderstand youth, for example, when we seek to swallow up the adolescent too soon into the adult "establishment"; when we want to transform him too quickly from a critic *of* the system into a complaisant apprentice *in* the system.

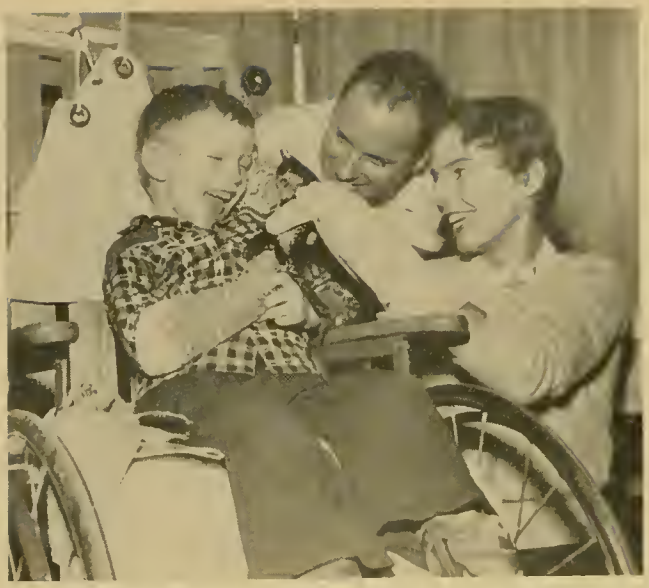
Here lies one danger: that as eager but unperceptive adults, insensitive perhaps even to what youth *is* in today's culture, and incapable therefore of knowing what youth's needs *are*, we in effect refuse to "let youth be young" and hasten the demise of what Edgar Friedenberg calls in his aptly titled book, "The Vanishing Adolescent." [1]

Another danger lies in the opposite extreme: unwillingness to recognize the capacities of adolescents for responsibility and reluctance to provide challenge and place for them. Thus we tend either to keep young people children or to try to prematurely make them adults. How can we treat them as youth? It is difficult, even for professionals working with adolescents, to understand youth in our times. To do this we must understand the nature of adolescence: what some of the stresses for youth today are; then the basic needs which derive from these stresses, as youth interacts with its culture and ours; and how youth copes with itself and with us, or to use the current term—the *youth subculture*. Only then can we see the implications which are here for adults who work with youth.

Adolescence is much more than one rung up the ladder from childhood. It is a built-in, necessary transition period for ego development. It is a leave-taking of the dependencies of childhood and a precocious reach for adulthood. An adolescent is a traveler who has left one place and has not reached the next. Erik Erikson calls adolescence a "psychosocial moratorium." [2] Edgar Friedenberg says that ". . . adolescence *is* conflict—protracted conflict—between the individual and society" [1] essential for learning the subtle and precious difference between self and society. Kasper Naegele speaks of it as an "intermission between earlier freedoms . . . and subsequent responsibilities and commitments . . . a last hesitation before . . . serious commitments concerning work and love. . . ." [3]

This "last hesitation" is turning out in America to be almost a decade—unprecedented anywhere in time or place. It is being lived through by 20 million human beings in the United States today. Their number may be doubled by 1970.

Based on an address presented at the Joint Conference on Children and Youth, sponsored by the National Committee for Children and Youth, the Federal Interdepartmental Committee on Children and Youth, the Council of National Organizations for Children and Youth, and the National Council of State Committees for Children and Youth, Washington, D.C., April 10–12, 1962. The full text of the address is being made available in pamphlet form by the National Committee for Children and Youth, 1145 19th Street NW., Washington 8, D.C., at 35 cents a copy, with a 20-percent deduction for quantities of 100 or more.



The joy of helping a child shines through the face of the teenage hospital volunteer shown here encouraging a young polio patient to use his hand, as a physical therapist looks on.

There is no good term to use for this period between childhood and adulthood. Each of the words we use is not really satisfactory, probably the result of our own state of confusion and unease when we speak of youth. "Adolescent" seems pedantic. "Young person" is too poor in connotation to be useful. The catchword "teenager" is apparently here to stay, but has a patronizing if not derisive sound. I like "youth," but this has been loosely used to include children and young adults. (In fact, most "youth-serving" organizations deal chiefly with children.)

Whatever term we choose to apply when we speak of this transitional phase of life, we must all agree with Erik Erikson that, "in no other stage of the life cycle . . . are the promise of finding oneself and the threat of losing oneself so closely allied."[4]

Stress Factors

To understand youth and adult institutions in this decade, we need to see adolescents on what Reuel Denney has called "a wider screen," the cultural milieu within which they struggle for identity and meaning.

The *nature of American society itself* in this century of turmoil, transition, challenge, and danger—the sheer scale of population and the magnitude and complexity of organization—offers both opportunity and difficulty to youth.

One of America's dominant values has been called by Talcott Parsons "instrumental activism," a concept of individual commitment to building a good life for the individual and for mankind. This is not a doctrine of passive adjustment to conditions, but one of active adaptation. It holds that society is meant to be developing in the direction of improvement through the autonomous initiative and achievement of individuals. In so evolving, modern society puts greater rather than lesser demands on its average citizen, who must operate in ever more complex situations than before. He must exercise progressively higher levels of competence and responsibility. Society's augmented demands tend to outrun the development of individual capacities. Here is a major source of unrest and anxiety, especially for youth who are "activistic," impressed with the importance of future responsibilities, and at the same time frustrated by lack of influence and power.

In this light, Talcott Parsons says:

> The current youthful indictments of the present state of our society may be interpreted as a kind of campaign position, which prepares the way for the definition of their role when they take over the primary responsibility, as they inevitably will.[5]

The *pace of social change* is a major stress affecting both youth and adults and the relations between them. Unrestrained and undirected technological change pervades all areas of life.

Says Kenneth Keniston:

> . . . a society changing in the way ours is, greatly increases the unpredictability and uncertainty of the life situation shared by all members of any generation. In almost every other time and place a man could be reasonably certain that essentially the same technologies, social institutions, outlooks on life, and types of people would surround his children in their maturity as surrounded him in his. Today . . . our chief certainty about the life situation of our descendants is that it will be drastically and unpredictably different from our own . . . all technologies, all institutions, and all values are open to revision or obsolescence.
>
> This alters the relationship between the generations . . . the past grows increasingly distant from the present . . . the future, too, grows more remote and uncertain . . . the present assumes a new significance as the one time in which the environment is relevant, immediate, knowable . . . the relations between the generations are weakened as the rate of social innovation increases. The wisdom and skills of fathers can no longer be transmitted to sons with any assurance that they will be appropriate for them . . . most affected are youths in the process of making lifelong commitment to the future . . . the young are most immediately torn between the pulls of the past and the future. Reared by elders who were formed in a previous version of society, and anticipating a life in a still different society, they must somehow choose between competing versions of past and future.[6]

The impact of social change suggests the next stress: the *discontinuities between age groups and generations*. The generation gaps are in time, be-

tween one mature generation and the next; but age group gaps are between different ages at the same time. Bruno Bettelheim suggests, "It may be that the problem of generations is what gives us adults so much trouble, and not the problems of adolescence or youth." [7]

Kenneth Keniston observes:

> . . . young people frequently view the more public aspects of adult life as empty, meaningless, a rat race, a future treadmill; only in private areas can meaning and warmth be found. Childhood contrasts sharply with this image; childhood is seen as . . . a time for the full employment of one's talents and interest . . . when imagination is given free play, and life has spontaneity, freedom, and warmth. Adulthood obviously suffers by comparison, and it is understandable that those who are being rushed to maturity should drag their feet if this is what they foresee.[6]

As Kasper Naegele has put it, "Suspended between a 'no longer' and a 'not yet,' youth is forced to balance continuity and discontinuity." [3]

This fact decreases the availability of adult exemplars. Even the most well-intentioned parents who, in more stable times would have been excellent models, cannot now hope to be complete exemplars for their children's future. Other adult exemplar roles are also indistinct. Many officials (teachers, guidance people, police, agency staff members), not to mention "non-officials" (disc jockeys, editors), confuse youth, and fail to give them a clear and disciplined way of facing themselves and the world.

There is also general *adult uneasiness toward youth*, which pervades our society.

Edgar Friedenberg suggests that—

> There is obviously something in adolescence itself that both troubles and titillates many adults . . . evokes in adults conflict, anxiety, and intense hostility . . . fear that the adolescent will get out of the adult's control and may also throw out of control situations in which the adult is involved. . . . Adolescent spontaneity frightens and enrages [them] . . . Fear of disorder, and loss of control; fear of aging, and envy of the life not yet squandered—these lie at the root of much adult hostility to adolescence.[1]

Bruno Bettelheim observes that—

> Many if not most adults have an emotional need for children and enjoy bringing them up . . . once childhood is past, however, the picture changes . . . most parents have little emotional need . . . for a youth striving to be free of its elders.[7]

Kasper Naegele puts it this way, ". . . our youths have come to receive the harsher side of our values, while our children receive the gentler." [2]

I suspect that a large proportion of youth workers and agency board members feel similarly about adolescents and so settle for the emotionally satisfying delight of serving children.

A major stress for youth stems from their *lack of place or role in our society.* They are without a share of the work of the community. They are too young to marry; largely excluded from employment; they do not participate in elections; there is no presently effective way for them to take part in the political, commercial, financial, or cultural aspects of the community. In a recent speech to the National Association of Secondary School Principals, Franklin Patterson of Tufts University said:

> . . . youth are passive students, consumers, dependents, and bored observers of the adult rat race. . . . Increasingly, we have placed youth in a social vacuum with nothing to measure themselves against except standardized academic achievement scores and peer standards that are evoked by advertising, consumer persuasion, and the disc jockey.

Another stress for youth is the *vacuum of challenging social goals* in our affluent, status-quo, defensive society. This is crucial for adults to understand.

Ours is not an age of dreams, visions, utopias, or large-range goals. If we of the older generation have lost our dreams, those of the younger generation are lost without them. Bruno Bettelheim says:

> The buoyancy of youth is fed by the conviction of a full life to come, one in which all great things are theoretically attainable. But one cannot believe in the good life to come when the goal is suburbia. One cannot realize one's values by climbing the ladder of the business community, nor prove one's manhood on the greens of the country club. . . . Neither our conviction that the West is declining nor our fear that atomic destruction will wipe man from the earth . . . offers much hope for assertive self-realization, now or ever . . . youth does not create its own cause for which it is ready to fight. All it can do is to embrace causes developed by mature men . . . age provides the direction but youth the leadership and fighting manpower.[7]

David Riesman says that youth needs the challenge of adequate social goals. He points out that "throughout Western history, men have imagined that collective as well as individual life could be better or, at least less bad." [8]

What are adequate social goals for an age of plenty? What new vision can give meaning to life? To Riesman, a vision of "a viable and conceivable society" to achieve individualistic values seems essential to the problem of meaning for life. This vision, he warns, must not become "fanaticism in pursuit of Utopian goals" nor an "intellectual swindle for True Believers." Adequate social goals, he asserts, must be "more than piecemeal and ad hoc" objectives, and also be bigger than short-run aims in a game with the Russians. He suggests that "immense and far-reaching changes in men's hopes and desires" are necessary to create a better world.

How do we stimulate what Riesman has called "the almost atrophied power of ordinarily unreflective people to think about a better society?"

Focal Problems of Youth

So adolescents, in search of self and meaning, live in an age and a society full of built-in stresses. The blend of adolescence itself and these stresses has produced some focal problems for them.

It is dangerous to generalize about any large population, especially youth. Says Reuel Denney:

> Youth can be so different from itself, as it moves from role to role, that it still maintains, even in a society devoted to publicity, a great capacity for concealment. This masquerade, and the range of youth, and the pace of change, make it difficult to generalize about the young.[5]

However, some focal needs do stand out for large sections of youth.

1. First is the *problem of identity.* Benedict, Erikson, Friedenberg, Block, Niederhoffer, and many others have stressed meeting the crises of identity as the first task of adolescence in a society which defines youth ambignously. The term "identity formation" is used in our day with faddish ease but it is a complicated process. It is essentially the creation of an inner sense of sameness and continuity, a unity of personality felt by the individual and recognized by others, a knowing of who I am. Crucial for all, it meets its crises in adolescence. Erik Erikson says, "The prime danger of this age, therefore, is identity confusion . . . . In youth ego strength emerges from the mutual confirmation of individual and community."[4]

Kenneth Keniston observes that, "socialization is the main problem in a society where there are known and stable roles for children to fit into; but in a rapidly changing society like ours, identity formation increasingly replaces socialization in importance."[6]

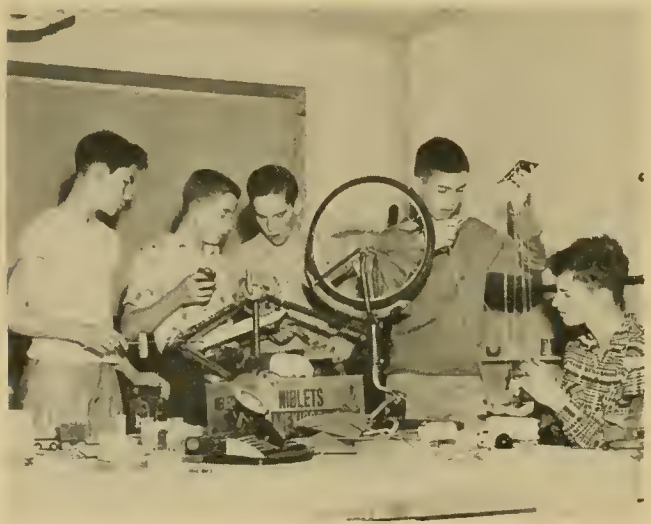
2. Related to self-identity is the *problem of self-esteem.* Edgar Friedenberg says:

> In adolescence, self-esteem is a crucial problem. There is as yet little experience to base it on. . . . The adolescent building his appraisal of himself is therefore extremely vulnerable to the feelings and judgments expressed by the persons and institutions of his immediate environment. . . . Adolescents lack *reserves* of self-esteem to sustain them under humiliating conditions . . . Adolescents are dreadfully concerned about society's appraisal of them and of their worth . . . They cannot easily assimilate an attack on their dignity or worth, for it produces not merely resentment but intense anxiety. The self is threatened while still ill-defined and in its early stages of construction. . . .[1]

3. A resulting problem for many youth is *alienation.* This is a term used frequently in connection with delinquency: alienation from parents, school, middle-class values, the community; alienation resulting from status deprivation; and alienation fed by hostility of adults and adult institutions. But delinquent or bohemian extremes of alienation are not the only forms. Some of our elite youth display signs of alienation from, and describe as alienated, the overstandardized man of their day. They are alienated from their parents' conception of adulthood. Thus alienation compounds the problems of adolescents by still further limiting the encounters with adults essential to clarification of identity.

4. A fourth focal problem is the prevalence of *privatism.* Here youth shares a response to the times in company with many adults. "Privatism" (a word used by David Riesman) is the cultivation of private experience, a pursuit of values least involved in the wider society and most manageable and controllable. Fun and peer pursuits should of course play a large part in adolescent life, but in privatism they hold an exclusive place. An extreme value is put on personal satisfactions, the hedonism of the moment, the refusal to consider future consequences or past commitments. Future and past disappear and only the intense present is sought. Privatism is a cult of experience. Yet privatism is a willful limitation of vision, fails to strengthen identity and self-esteem, and leaves unmet the hunger for meaning, purpose, and direction.

Toymaking in a YMCA shop gives these boys a chance not only to exercise their mechanical aptitudes but to attain the satisfactions of doing something for others.



5. The fifth focal problem is the *lack of commitment to adult values and goals.* Kenneth Keniston puts it this way:

> . . . a surprising number of apparently ambitious young people see . . . the adult world into which they are headed as a cold, mechanical, abstract, specialized, and emotionally meaningless place in which one simply goes through the motions, but without conviction that the motions are worthy, humane, dignified, relevant, or exciting. Thus, for many young people, it is essential to stay "cool"; and "coolness" involves detachment, lack of commitment, never being enthusiastic or going overboard about anything. . . .[4]

There is general apathy before world problems of great magnitude. This, says Keniston, is due to "the feeling of public powerlessness, the emphasis on the private and immediate aspects of life, the feeling of disengagement from the values of the parental generation," and to real anxiety when thoughtful people "contemplate their own helplessness in the face of social and historical forces which may be taking the world to destruction." Keniston adds:

> In a generation as in individuals, the conviction of powerlessness begets the fact of powerlessness.
>
> For few young people are deliberately cynical or calculating; rather, many feel forced into detachment . . . because society seems to offer them so little that is relevant, stable, and meaningful. They wish there were values, goals, or institutions to which they could be genuinely committed. . . . It is ironic that this generation, which is better prepared than any before it, which knows more about itself and the world and therefore is in a better position to find those points of leverage from which things can be changed, should feel unable to shape its own destiny in any public respect . . . an alienated generation seems too great a luxury in the 1960's.[5]

The Youth Subculture

Always ingenious, youth has contrived its own world, or worlds, of unique special subcultures. They are essentially devices, mechanisms, inventions of teenagers to meet and cope with their condition of life in our society. Teenage culture is a variegated complex of values and behavior patterns, contrivances which provide the means for testing one's self, for reconnaissance, for searching for identity, ego survival, and growth, for meaning and self-esteem, for coping with alienation, adult hostility, and societal forces, and for resolving the discontinuities between childhood and adulthood, on the one hand, and bridging the gap between the generations, on the other. Adults should be thankful for youth's ingenuity and less judgmental as to its forms.

Keniston calls the youth culture:

> . . . a kind of way station, a temporary stopover in which one can muster strength for the next harrowing stage of the trip. The youth culture is becoming more and more important in our society at present and involves a greater and greater part of their lives . . . it has roles, values, and ways of behaving all its own; it emphasizes disengagement from adult values, sexual attractiveness, daring, immediate pleasure, and comradeship in a way that is true of neither childhood nor of adulthood. . . . [It] is not always or explicitly anti-adult, but it is belligerently *non*-adult.[6]

Jessie Bernard points out that not all youths participate in the teenage culture: 4½ million are in the civilian labor force, more than a million are married; 900,000 are in military service. Thus about 6½ million out of the 19 million teenagers "are chronologically, but not necessarily teenagers. They are neophytes in the adult culture . . . expected to perform adult roles in adult dress." But in the younger years practically all youth, regardless of class, are in the teenage culture. And, according to Dr. Bernard, the phenomenon appears to be moving downward in age.[10]

Space permits only the briefest mention of some of the features: special language, clothes, performing idols, teenage magazines, and tribal customs of early dating, going steady, and meeting at hangouts. But there is no monolithic youth subculture. There are important variations between middle-class and lower-class urban, between urban and rural, and between younger and older adolescents. There are submotifs in the American teenage cultural mosaic and in different parts of the world. Joseph Himes described a Negro teenage culture, Robert Bealer and Fern Willits highlighted rural youth, David Boroff characterized a Jewish teenage culture, Francis Ianni portrayed an Italo-American teenager, John Barron Mays characterized a teenage culture in contemporary Britain and Europe, all in *The Annals* for November 1961, published by the American Academy of Political and Social Science. In the Winter 1962 *Daedalus*, journal of the American Academy of the Arts and Sciences, there are perceptive articles on Japanese youth by Robert Jay Lifton, youth in France and the United States by Laurence Wylie, and on Soviet youth by George Sherman.

The varieties reveal differences in the nature of the stresses and the corresponding variations in the responsive attitudes and behavior of youth. But the variations tend to strengthen and illuminate the broad contours of the universal phenomenon: industrial society's teenage culture as an interlude, a sort of *rite de passage*. As Francis Ianni points out, the forms change over time, each form being what L. L. Bernard called "'transitory behavior'—scarcely established as a pattern before it changes again."[11]

No feature of the youth culture is as central and as universal as the *peer group*. "To learn how to exist in a society independent of his parents," says

Ira Reiss, ". . . [the young person] transfers his dependence to his peers and strives to learn from them the secrets of entrance into the adult world." [12] Peer relations is the area least under adult control. Youth, as Reiss has pointed out, has also shown adaptiveness in working out its sexual codes.

The broad band of teenage peer culture, its variations, as well as its extremes, are means for coping.

As Reuel Denney suggests:

> In certain ways, modern American young people seem to walk on eggs more than any generation in the 20th century. Their talent for the "delayed reflex" may prove to be one of our main resources in the coming culture and politics of the nuclear age.[9]

Implications for Adults

What does all this imply for adult institutions? Can we do more things or different things to provide challenge for this generation of youth?

There are things we might do, if we do them sensitively and imaginatively; if we do them as enrichments to the teenage culture rather than as assaults upon it; if we do them in a spirit of experimentation, as learners with youth in a common search for meanings. Here are six areas of challenge for youth which adult institutions might foster:

1. The *challenge of competence* in self-fulfilling activity. "Competence is the foundation of autonomy." says Edgar Friedenberg. "In adolescence it it is almost a religion . . . ." [1]

Many fruitful areas of experience requiring disciplines of competence are not accessible to young people acting on their own. A variety of artistic, athletic, intellectual, and mechanical resources can have meaning for adolescents. Skiing, pack trips, sailing, bowling, ice and roller skating, creative writing, drama, music, the graphic arts, intellectual inquiries, hi-fi and radio building, mechanical work on cars, are just a few examples. What is important here, of course, is not the activity itself, but the stimulus to competence which it provides, along with the contributions to self-identity which come with sharing a common reach and respect for competence. Thus, we must offer not leisure time activity, hobbies, and recreation just for fun, but activities which challenge competence.

2. The *challenge of understanding.* Thoughtful adolescents should be encouraged to understand the meaning and importance of their particular stage in life and some of the problems which affect their generation. The nature and function of adolescence, the stresses produced in our time, the crucial problems of identity, self-esteem, alienation, privatism, commitment to future goals, and the varieties of the youth culture at home and abroad, including deviancies, are matters which older adolescents can understand. Inquiry groups, focused upon youth's world, could provide important challenges to understanding. Keniston says, ". . . a concrete understanding of the psychosocial forces that affect a generation might have some of the same therapeutic effects on the more reflective members of the generation that insight into psychodynamic forces can give the thoughtful individual." [6]

3. The *challenge of a truer public image.* The excessive publicizing of that fraction of our young people who deviate from the society's norms of behavior, and of their counterparts in other countries, and the mass media treatment of teenagers in general present a distorted and derogatory image of youth in our culture which adds to the prevalent adult uneasiness about youth and ignorance of its lot in society today. Because youth gets a bad press, it has reaped a poor public image. This affects youth's self-esteem. Need we be surprised if some young people choose to live up to this billing?

Adult institutions can do much to correct youth's distorted public image. They can begin by reducing their own share in the distortion. Unfortunately, many agencies, seeking support in their fund-raising efforts, inflate their importance by exaggerating the "Youth Problem." Some agencies build a case for their work with children by dramatizing the needs of adolescents, with whom they actually have slight contact.

Youth-serving institutions could become the public relations and press agents for a more positive image of youth, if part of the energies their public relations staffs spent on *institutional*-image making were devoted to truer *youth*-image making.

4. Next is the *challenge of work and responsibility.* Youth has very little chance for work and responsibility which uncovers and taxes their powers. Adults could provide youth with many more opportunities for meaningful involvement and responsibility. A promising start is being made: programs of part-time employment and part-time schooling in deprived areas of large cities; work camps; summer "workreation" programs in public recreation centers; social service opportunities for teenagers in hospitals, children's institutions, camps for crippled and mentally retarded children, play centers,

and Red Cross volunteer programs. In Boston, through Operation Kindness, over 7,000 students have served in 106 cooperating agencies.

We have only begun to apply imagination in these directions. Every institution dealing with youth can find some work opportunity within it, and can enlist help in the community.

There is danger of superficiality here. The value is not in the mere performance of some responsibility, but rather in the meaning it comes to have for the individual, in the stretching of capacities, in the development of competence, in the heightened self-esteem, and in the social commitments it fosters.

5. The *challenge of role models* or exemplars. What youth is and will become is determined more by the small groups of the creative young than by its majority members. Therefore providing a platform for talent, recognizing and rewarding the creative young, may be a way of fostering peer role models. Athletics does this now, but almost alone.

Poetry and music festivals and art exhibitions with scholarship awards; opportunities for the creative to appear before their own peers and before adults to read a poem, explain a piece of scientific work, display a painting, sing or play, or explain some volunteer work activity—these could be fruitful ways of encouraging the emergence of role models to replace the "sorry succession of Elvises" [1] produced by the communications industries. Fortunate is the adolescent who has found a good adult model, a temporary self-ideal who can tolerate adolescent confusions. Too many adults fail the teenager, either because they are unsure of themselves, or because they are *too* sure, imposing unrealistic standards on youth. Some, but too few professionals—teachers, youth workers—are good adult role models. Broadening the range of adult relationships through work responsibility increases the probability of young people finding some worthy adult models.

With an obvious sense of competence, this young teenager exhibits his own tobacco crop, planted as a 4-H Club project.

6. And last, one of the most important challenges of all, which adult institutions might strive for, is the *challenge of commitment to a better future for mankind.*

"We need not only a rediscovery of the vital ideals of the past," writes Kenneth Keniston, "but a willingness to create new ideals—new values, new myths, and new utopias. . . . It is for such ideals that young people are searching." [6]

Bruno Bettelheim says:

> Old age is happiest when it can take youth up to the threshold of the good and the new and . . . point out the Promised Land to its children, saying: "you and only you in a hard fight will have to make this your own." . . . Youth, on the other hand, is happiest when it feels it is fighting to reach goals that were conceived of but not realized by the generation before them. . . . the hope of the future—this is the legacy of youth.[7]

Riesman suggests engaging youth in speculation about the kind of world they would like to live in.[8]

To generate challenge for future goals is different from engaging in discussion of current problems with their conflicts and technical difficulties. Exclusive exposure to the headaches of the day can only increase youth's anxiety.

For example, today we are witnesses of history's greatest news story: the fabulous era when man takes off from Planet Earth and sets his compass for the stars. This news story can be viewed in terms of the technicalities and economics of the space program; in terms of a race with the Russians; or in terms of the threat of increased potential for mass destruction. But it can also be viewed as the challenge of unlocked secrets of life and the universe, bearing upon man's long quest for the meaning of his place in the universe. The space age can be regarded, as President Kennedy stated at the University of California on March 23, as offering us "an area in which the stale, sterile dogmas of the 'cold war' could be literally a quarter of a million miles behind." The President said:

> The short view gives us the impression of a nation being shoved and harried, everywhere on the defense. But this im-

pression is surely an optical illusion. . . . Wisdom requires the long view. And the long view shows . . . that the wave of the future . . . that the great currents of history are carrying the world away from the monolithic idea toward the pluralistic idea . . . the liberation of the diverse energies of free nations and free men. . . . Beyond the drumfire of daily crisis, therefore, there is arising the outlines of a robust and vital world community, founded on nations secure in their own independence and united by allegiance to world peace.

These are inspiring words for young people who will live part of their lives in the 21st century.

Why not nurture youth on dreams instead of nightmares? As adults, we all wrestle with the nightmares of our age: problems of urban sprawl, obsolescence in our cities, transportation congestion, air pollution. Our piecemeal planning and governmental inadequacies for dealing with these situations are often presented to youth as a frightening combination of technical problems. Instead of the nightmares, let us present youth with the dream of making our urban environment humane, of transforming whole cities into parks with the help of architects, developers, and artists; of changing our distrust of coordinated planning; of diversifying and coordinating all methods of transportation; of protecting our woodlands and multiplying recreational resources.

Each of our problems can be looked at either in their distressing near view or in a hopeful long view. They are the two sides of the shield. Youth has nightmares enough of his own; he needs our dreams. Adult institutions can expose young people to those adults who have dreams, who can suggest vast fields to conquer, who can turn vital issues around to reveal goal rather than dilemma. And adults who have achieved planned change in their corporations, government activities, or schools can tell youth how it was done, as proof that we are not all powerless in the grip of impersonal forces.

The telescopic lens, focused upon the exciting jobs ahead in the rest of this century, can assist "young people to rebel against certain unworthy aspects of the social structure . . . ensure their allegiance to the fundamental philosophy which is the foundation of our civilization . . ." [13]

To do any of the things that will render youth stronger and more capable of coping with the challenging conditions that face civilization in the second half of the 20th century, calls for soul-searching on the part of adult institutions. Let us not always assume that it is the youngster, rather than the relationship, the school, or the institution that needs readjusting. Institutions need to put themselves to the test of understanding youth; to the test of respect for adolescents; to the test of creativity and adaptability; to the test of worthy objectives and goals.

At the greatest moments in the American past, Americans had an image before them of what free men, working together, could make of human life. The great question that the present generation of Americans will answer is whether . . . American life can be lit by a sense of opportunities to be seized and great things to be done.[14]

Can we help youth hitch its wagon to the stars? Can we help make youth capable of creative achievement in the balance of this century? May we, in our impact upon youth, be touched by the flame of the creative spirit, which alone can make ideas contagious and faith believable.

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Treatment of the delinquent begins with the hearing and thus calls for . . .

ORDER IN THE COURT

WILLIAM T. DOWNS

Deputy Administrator, Supreme Court of Michigan

LIFE GOES ON both before and after a court hearing. Yet, the juvenile courts often seem to ignore this obvious fact.

Not long ago a judge remarked to me that since the hearing is only incidental in the life of the family concerned, it makes little difference how the hearing is handled. He seemed totally unaware of the possibility that it might be his very handling of the hearing which made it of so little consequence.

There are reasons for such an attitude. The pattern for our juvenile codes was set in the decade following the turn of the last century. At that time there was an understandable reaction against the rigid formality of the civil and criminal courts. *Relax, be informal* was the watchword. Unfortunately, the stress on informality brought with it elements of confusion and disorder. It is now time for a reappraisal.

Millions of words have been written about the treatment of juvenile offenders, but almost invariably their focus has been on the treatment which takes place after the order of disposition is entered by the court. While occasional references are made to the fact that the entire court process is a treatment process, these are usually incidental to a presentation of some other point. In fact, it seems impossible to arouse interest in this aspect of juvenile court activity.

In conversation, the minds of individuals concerned professionally with problems of delinquency, whether judges, lawyers, social workers, psychologists, or what you will, seem to leap automatically to either what they believe to be the environmental causes of delinquency or to the treatment of the adjudicated delinquent.

There has, however, been some implicit recognition of the importance of the court process as treatment in such oft-heard remarks as this or that girl or boy will be of no further trouble because attendance at the court was "enough."

Some time ago, social workers were writing about the traumatic effect of the court hearing. They realized that the court appearance was a frightening and significant event in the life of the child and that the accompanying worry and tension could produce a detrimental effect on the child. Therefore, they sought to lessen the impact of the occasion by making the child feel at home at the hearing. The social workers were right in their estimate of the impact of the court appearance on the child. A court appearance has a tremendous impact on every lay participant, even on impersonally involved witnesses. It is a mistake to dismiss any court appearance as of no consequence in the minds of the participants.

However, to say this tension and anxiety stem from the formality of the courtroom is a mistake. While it is true that a harsh, unsympathetic judge will strike fear in the hearts of those before him, such a judge is not really a part of the average court.

The tension and anxiety are largely due to natural suspicion of things unknown, guilt about past wrongs (perhaps undiscovered), and a face-to-face meeting with the authority of our society.

To the people before the court, the court will always represent authority. As one woman put it, "You're so much in their hands."

No matter how much court personnel may deceive themselves about being a friend to the boy, or acting as a kind father, or offering help and not punishment, they cannot disassociate themselves from authority in the minds of the respondents. I believe this is good. This is not to say that the juvenile court should not be a friend, should not be kind, should not be compassionate and understanding. It is to say that the court's authority is a fact of life.

In our concern with the "traumatic" effect of the court appearance and our attempts to lessen its impact by making the participants in juvenile court feel "at home," we may have lost more ground in reaching the goals of treatment than we have gained. While recognizing the position of the individual in court, we have sometimes failed to recognize the place of the court in the overall scheme of law enforcement, and have therein failed to apply a true concept of the court process as part of the treatment process.

The Court as Authority

What is the place of the court in this scheme of law enforcement?

Few would deny that some rules or laws are necessary if people are to enjoy their rights to life, liberty, and the pursuit of happiness—including, in our society, the right to acquire and retain material possessions. In our society the elected representatives of the people enact these rules as laws, and define those acts which are contrary to them. Thus society, through the legislature, has forewarned its members that commission of these acts will lead to a further expression of its disapproval. Most juvenile offenses were first defined in relation to adults, juveniles being blanketed in later through the juvenile code. When a person commits a forbidden act, the police express society's disapproval by apprehending him.

In our country we are rather proud of the fact that we recognize not only society's right to law and order, but also the right of the individual to be free from unreasonable restraint or interference. We try to maintain a balance between the rights of society and the rights of the individual.

This balance is often difficult to find and maintain. Learned men can debate for hours about what it is in a given situation. Nevertheless, all through their education young people have been told of these rights and this general scheme of things. They have been told that the court is the final authority in these matters. For example, a widely used high-school text says:

> All courts have the duty to administer justice to all American citizens.
>
> If the accused cannot pay for a lawyer, the court will appoint one to serve without cost.
>
> When an American citizen is accused of a crime, he may be released on bail (an amount of money fixed by the judge) unless he has been accused of a serious criminal offense.
>
> An American citizen cannot be forced to give evidence against himself . . .
>
> If his trial goes against him and he is still convinced of his innocence, he may, under some circumstances, appeal his case from the State court to a Federal court . . .

Underlying all these rights is this one:

> An American citizen is assumed innocent until a trial has proved him guilty.[1]

So I suggest that the youth and his parents approach the court with a deep conviction about the following facts: that the court is the final authority for the expression of society's disapproval of any violation of its laws; that the court is the final authority in the protection of the individual against unreasonable encroachments on the part of society; and that the court is the part of the Government which applies society's sanctions for antisocial behavior.

Both in society's control process and in the minds of the youth and his parents, a juvenile court is like any other court with regard to these basic functions. One major purpose of the court is to *reestablish respect for duly constituted authority.*

Responsibility for Behavior

Those of us who believe in the juvenile court believe that it is something more than any other court. We believe that the juvenile court is designed to offer "individualized justice"; that it seeks to understand the child and to realize that his behavior may be a result of an antichild environment. We believe that a proper use of the social sciences can increase this understanding. And we believe that the broad range of discretion given to the juvenile judge makes possible an individual custom-designed treatment instead of punishment. (Of course, the discretion is nought but a word, and the treatment is but air, if there are no means with which to carry them out.)

While I agree with this philosophy, I suggest that in our eagerness to apply it to the individual, we may have obscured certain facts about the general welfare, and may have created new dangers to that welfare. We may have overlooked the place of the

court in the overall scheme of societal control. In seeking to understand the child's behavior we may have inadvertently seemed to excuse his behavior. That is to say, in our court process, we may have seemed to regard the individual's behavior as though it were a conditioned response to his environment, like the responses of laboratory mice in a maze.

How often have I heard the remark in court, "He's not to blame; what else can you expect?" Such a remark disregards the fact that thousands of children from broken homes, or slums, or minority groups grow up to be good citizens. It ignores the fact that as God's creatures we are all blessed with a freedom of choice to make of ourselves what we will. It seems to me that while justly abhorring poverty and the handicaps it imposes on young people, we have erred in implying that children in certain circumstances do not have the freedom to choose between right and wrong.

I am not advocating severe punishment for juvenile offenders or "criminal court formality" in juvenile court. I am suggesting a new look, a reappraisal of what the juvenile courts are expected to do, and how they are doing it. And I suggest that the focus of this reappraisal be on the court process itself, from point of intake to point of disposition.

If we are correct in saying that to the child and parents the court represents the final authority of society, this fact should be recognized in the manner in which the court approaches these individuals. If the court is designed to represent and express the authority of the people, then it must properly play this role to be truly effective.

If the court by its very nature represents authority, then the court and all its members must behave in a suitable manner. The court, as a social institution, cannot behave as some judges are fond of saying they do, like a "wise and understanding father."

Even if it were desirable for the court to assume the role of a wise and understanding parent, it should be remembered that such a parent plays many roles in his relationship with his child, one of which is to require obedience. It is in this aspect of the father's role that the court is cast when it deals with a juvenile offender.

When I refer to the court, I mean the court and everyone who works for the court. The social worker, caseworker, intake worker, probation officer, or whatever he may be called, is a *court* social worker, a *court* caseworker, a *court* intake worker, a *court* probation officer. To the people, every court employee represents the authority of the court. It is an illusion to speak of voluntary casework in a court setting. In the minds of those with whom a court deals, there is an element of *duress* in every word spoken.

This essential role of the court in society should preclude it from extending its operations to areas of service to children or families which do not require the use of authority. Philosophically speaking, such extension raises the basic question of when the use of force is compatible with the freedom and dignity of the individual. Practically speaking, it dilutes the court's attention to its essential functions and confuses the young offender and his family as to the court's role. This can diminish rather than strengthen their respect for law and order.

Judgments at Intake

The day-to-day application of this theory of the operation of the juvenile court requires two essential judgments to be made at intake by the unit assigned by the judge for screening purposes: Does the specific act complained of fall within the juvenile code? And is the authority of the court necessary in this instance? These oft-mentioned prerequisites to juvenile justice are more honored in the breach than in the observance. People have a right to be free from interference in their lives. If they have done nothing which the law has said is wrong, the court has no right to enter their lives.

Courts may have the best intentions, but if there is no legal basis for their actions their intentions will not save them when their bluff is called. And it will be called, and respect for the law be further undermined. If the act the young person is charged with does not fall within the juvenile code, the court should not take cognizance of the matter, officially or even unofficially. A referral to another agency is of course often advisable.

Even if the act falls within the code but it is apparent that the child or family can solve their problem without court action, then none should be taken. How can the courts, which often harp on the decline of family ties and the lack of parental responsibility, possibly justify injecting themselves into situations in which the family is willing to work out its own soluton? Certainly when a youth solves his own problems he acquires better character training than when the court dictates a solution. Only if it appears that the authority of the court is necessary to a solution should the court act. This principle holds true for any stage of the proceeding. If and when it appears that court authority is no longer

necessary, then the matter should be dismissed.

One beautiful, unique feature of most juvenile codes, but one which is least understood, is the discretion of the court *not* to act.

The intake posture of juvenile courts has considerable sociological implication, and has much influence on value patterns in any community. Much has been written about the fact that our children no longer have room to grow. An eminent jurist told me recently that he had looked over the Glueeks' table for predicting delinquency[2] and had found most of the factors listed there to be qualities he had always associated with leadership and with our outstanding citizens. In some ways society has become intolerant of the foibles of youth. The court then must be tolerant if it is to fulfill its oft-mentioned role of protection. Serving as a bulwark against intolerance can be a much higher order of protection than the employment of caseworkers to help "predelinquents."

Our concepts of individual freedom and of the juvenile court should rightly afford the child an opportunity to grow, to make mistakes, and to develop his individuality. A court which has an all-inclusive policy at intake threatens this freedom and inhibits this growth.

Preparation for Hearing

The intake worker should remember that court intake is a part of the continuing law enforcement process. A court hearing is to follow and the police action preceded. Neither the intake worker nor the worker who prepares the social study for the judge should by word or attitude criticize the police. If he does so he will not only create very real administrative problems, but he will make the entire treatment of the youth more difficult. Such an attitude criticizes the entire law enforcement process and seems to the child to make light of his transgression. Moreover, just as a child is quick to sense a difference of opinion between parents, and work one against the other, he is also quick to make use of a difference between court and police personnel.

Occasionally boys and girls are the victims of irresponsible police action, but this is rare. In his efforts to "protect" the child, the court worker should not assume that the police are wrong and the child is right. While the worker tries to convey an attitude of understanding, he must let the child know that he has broken the rules of society and that society rightfully disapproves. The worker conveys this, not so much by words, as by attitude. He should be serious, not jocular; firm, not harsh; understanding, not excusing.

During both the intake and study process the worker must think not only of preparing the facts and paperwork for the court, but also of preparing the youth and family for the hearing. He should emphasize society's demand for respect for its institutions, and the court's fairness. He must impress the seriousness of the business upon the young delinquent.

Obviously, the matter should not go before the judge unless it is serious business. Let us not have 9-year-olds in court for stealing a candy bar. The court staff must make use of its knowledge of child and adolescent behavior, and discriminate between what is normal misconduct and conduct which truly represents a defiance or disregard of society. The court docket cannot be cluttered with the former, if it is to be free to perform its true function in regard to the latter.

The court team will fortify the moral values of society by dealing with serious matters in a serious way, and not by making a Federal case out of a trivial matter.

The Hearing

Some courts commonly excuse one parent (and occasionally both parents, or the only parent) from the hearing because of inconvenience or interference with work. In my view this is wrong. The matter should not come to a hearing unless it is serious; and if it is serious it demands the parents' attention. A hearing may be scheduled at a time within the court day which will accommodate a parent, but the parent should not be excused from attending. In excusing a parent, the court fails to treat the family unit. In postadjudication treatment we have learned that the best treatment of the child is of little avail, even though he is fully cooperating, if the family is not treated at the same time.

The objective of all treatment is a change in the individual, but a change in a child's attitude will not endure against the onslaught of the old parental attitude. This accepted axiom in the treatment of the adjudicated juvenile offender holds true for the court process itself. If the court does not insist on parental participation, by warrant if necessary, the court is failing to recognize this principle. Furthermore, the court is in effect saying that the $3, $5, or $20 the absent parent may be earning during the time of the hearing is more important than the child's welfare. If the court and agency workers show a

respectful attitude toward the hearing, the respondents will follow their lead.

While there may be validity in providing a relaxed atmosphere for the child in court, this does not hold true for the parents. In fact, the reverse may be true. Parents are often the real source of delinquency in children. If we are to emphasize parental responsibility and respect for authority, then the parents should be impressed with the seriousness of the matter. Since the hearing is part of the treatment, and the treatment must be applied to the family as a unit, the hearing should be conducted in a way that will accomplish this objective. The hearing follows the police effort and the court investigation, and precedes the implementation of the disposition. Like all these processes it is but a part of a continuing law enforcement process. It is not the final act, but is preparation for what is to follow.

The hearing is a traumatic experience, every detail of which is etched into the minds and memories of the children and parents involved. If those memories are to be a springboard for successful treatment thereafter, it must have order and dignity, without excessive formality. It must be carried out with both firmness and understanding.

At the same time, the court must show respect for the dignity of the individual. If there is one memory which should linger after the hearing, it is that of *fairness*. If there is one impression which makes further treatment of the young person almost impossible, it is that of having been treated unfairly. Most courts probably act fairly, but this is not enough. They must be sure that the participants understand what has taken place, and why it has taken place, and that it is fair. They must look at what they are doing through the eyes of the adolescent.

Sometime ago, I observed a hearing in a court known for its approved informal atmosphere. Seated at the head of the room was the judge. On his right was the court stenographer. Directly before the judge was a long table. On one side of that table were two assistant prosecuting attorneys, a police officer, and the court probation officer. On the opposite side of the table sat an undersized 15-year-old boy, alone. Other police officers and court workers were around the room. I have forgotten the case and the names involved. The mental picture of that scene remains with me and I suspect that it remains with the boy. With that picture is an impression of essential unfairness.

This troubles me. I know the judge and I know that he is of the highest caliber. I know that he is absolutely fair. Yet the impression of unfairness remains.

I do not mean to point the finger of blame at the juvenile courts or at any group which has influenced their development. Almost without exception our juvenile codes contain no detailed provisions concerning the conduct of hearings, other than a vague reference to an "informal" hearing.

As the number of juveniles coming before our courts has increased tremendously, the confusion occasioned by the lack of attention to the conduct of the hearing has become more apparent. We have the anomalous situation wherein a court which was intended to give greater protection to children than had been given to adults now jeopardizes the rights of those children.[3] Further, the court is often not performing its function as part of the treatment of the individual, but may even be inhibiting that treatment.

There is something reassuring to all human beings about an orderly process. This is particularly true of children. We can be kind and considerate, but at the same time recognize the child's right to order and authority. We can have order without excessive formality.

The juvenile court presents a tremendous opportunity for good in our society, but its potentials will not be achieved unless it carries a real sense of its objectives and of their urgency. This means that the courts must take a deep look at what they are doing and where they fit into our whole scheme of government. We must stop thinking of the court as only a switchline connection to facilities or treatment. We must look at the court process from the point of view of the child and his parents, and then make a real effort to put into practice the concept that the court process is part of the enlightened treatment of the individual.

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A study of 600 adolescent patients in social hygiene clinics . . .

TEENAGERS AND VENEREAL DISEASE

CELIA S. DESCHIN

Associate Professor, Graduate School of Social Work, Adelphi College

RECENT INCREASES in venereal disease among adolescents in the United States—a rise of 130 percent in reported cases from 1956 to 1960—make it imperative to clarify our own as well as the young people's attitudes toward sex; to replace ignorance with knowledge, and community apathy with appropriate action; and to take a critical look at the laissez-faire attitude of some public health authorities toward physicians who do not report the venereal disease patients they treat in private practice. The history of medicine makes it clear that attitudes toward disease have constituted significant factors either in facilitating or impeding control. Therapy alone—even when effective—has not proved sufficient to control disease unless supplemented by education and by appropriate changes in social institutions and in human behavior.[1]

With this in mind the American Social Health Association in cooperation with the New York City Department of Health undertook a study of the attitudes of teenaged venereal disease patients for the Public Health Service, U.S. Department of Health, Education, and Welfare. Begun in September 1958, the study was completed in March 1961. It involved interviews with 600 teenagers attending the social hygiene clinics of New York City, and visits to the homes of 100 of them.

Although the study was designed to include the patients of private physicians as well as of clinics, too few of the former were referred to the study to make any comparisons possible. This was a reflection of physicians' traditional reluctance to report their patients—a major factor in hampering efforts toward eradication of the disease and in preventing precise calculation of how many teenaged patients there may be in the nonclinic population.

Some preliminary field work indicated that venereal disease patients, including teenagers, were treated as if the disease existed apart from a human being. To be sure, the patients were urged to return should they become reinfected. However, a clinic policy of moral neutrality can be misinterpreted by the young patient as a quasi-acceptance of the sexual activity through which he has become infected.

At the time the study was initiated, little was known about the teenaged venereal disease patients in New York City. As director of the study, I was warned by both social hygiene clinic personnel and social workers in community agencies dealing with problems of youth that such teenagers were "delinquents" from demoralized families with little potential for rehabilitation and that they would certainly not talk to adults about their sexual behavior or related aspects of their lives. It was suggested that young interviewers be engaged and some form of payment be provided to the interviewees.

Not entirely convinced, I did some exploratory interviewing in one of the city's social hygiene clinics in a district health center where the physician in

Based on a paper presented at the 1961 annual meeting of the American Public Health Association.

charge did not share these stereotyped views. From the beginning, the response of the teenagers was friendly, interested, and cooperative, despite some initial resentment at having to prolong a visit to the clinic that sometimes took up to 3 hours, because of the unavoidable delays common to busy, walk-in clinics. Similar cooperation was subsequently met by the study interviewers—all of them adults who were trained and experienced social workers. In order to obtain 600 voluntary interviews, we had to approach 610 teenagers. Only 3 of the 10 refused outright to be interviewed; 5 were persuaded by persons close to them not to participate in the study; and 2 withdrew. Word soon got around that the study was a "Junior Kinsey" and that the interviewers were "OK." No one was paid and the teenagers were told that any results could not come soon enough to be of direct benefit to them. Where problems were revealed with which they or their families needed help, referrals were made through the charge nurse to appropriate agencies. The young people seemed eager to make a contribution to the study.

The Interviews

In each interview the objectives of the study were outlined briefly and simply and the importance of accuracy was stressed. The young people were given an opportunity to withdraw at any point if reluctance or serious inconsistencies were noted. The interview schedule, which was evolved during the exploratory interviewing, took from an hour to an hour and a half to complete. The teenagers were asked to provide data concerning their socioeconomic and cultural backgrounds; family status; education; religious affiliation and church attendance; leisure-time activities; employment; sexual activities, knowledge, and attitudes; feelings of guilt or religious conflict concerning their behavior; self-evaluation; and social adjustment, ranging from evidence of socially deviant behavior, sexual included, to their identifications with adults, their goals and self-images.

Parents accompanying teenagers to the clinics were interviewed as were parents in their homes.

The social workers involved in the interviewing were given training in research. The confidentiality of the information obtained in the clinic interviews was protected by having the home visits made by a social worker who did not do any clinic interviewing. In view of the limited knowledge available concerning the teenaged venereal disease patients and the unpredictability of the flow of patients in the clinics, we decided to interview all who came to the clinics during the period the primary data were being collected—February through August 1959. This means, of course, that the findings cannot be generalized until validated or invalidated by follow-up studies in New York with nonclinic patients and by comparable studies elsewhere.

Essentially an effort to determine factors contributory to the increase in venereal disease among adolescents, the study was designed to answer questions pertinent to the epidemiological aspects of control, including the following:

What kinds of teenagers are involved in venereal disease?

From what kinds of families and social backgrounds do they come?

From the above flowed a variety of specific questions. One was:

Are there significant differences in their social behavior depending upon their social background as a whole; or depending upon age, ethnic group, religion, family stability, education, employment, self-image, aspirations, and adult identifications?

A question of a general nature, included to bring out some of the extrafamilial influences that conceivably might be having an influence on both teenagers and their parents, was:

Are there trends in 20th-century American life that tend to exert pressure on the adolescent toward premarital sexual experimentation?

In the final report of the study,[2] this question is answered in the affirmative on the basis of a comprehensive analysis of the kinds of stimuli and social sanctions which induce young people to experiment sexually in the absence of comparable stimuli toward experimentation in nonsexual activities.

Findings and Implications

Who were the teenagers and from what kinds of families did they come? To what extent did identification of both fit the prevailing stereotypes?

While it is not possible here to describe findings that cover four chapters in the published report,[2] some significant findings and implications can be highlighted.

While all the teenagers interviewed had had sexual relations, only 63 percent were found by the

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clinic to have had one or more venereal infections. Of these, 70 percent were boys; 30 percent, girls. Among the infected group, numbering 379 teenagers, 159 reported 1 previous infection; 55 reported 2 or more.

Promiscuity, defined as casual, frequent, and depersonalized sexual relations, was a predominantly male phenomenon in the study universe. It was determined on the basis of number of sexual partners, length of time the teenager had been engaging in sexual activities, and personalization of the partner. The 600 teenagers—aged 12 through 19—were more evenly divided between boys and girls, 352 and 248, respectively, than the differences in promiscuity reflect. Only 2 girls were in the most promiscuous group as against 60 boys, while 5 times as high a proportion of the girls than of the boys were in the least promiscuous group. While society's greater acceptance of promiscuity among males may have occasioned some exaggeration on the part of the boys and some underreporting on the part of the girls, there is little reason to believe that this appreciably affects these comparisons.

Homosexuality was also much more prevalent among boys, with only 9 girls so involved out of a total of 115 teenagers who reported homosexual activity.

Tabulations to check the reliability of responses, checks for consistency, and the information obtained in the home visits confirmed the interviewers' impressions that the teenagers provided essentially accurate data—subjective as well as objective. Additional confirmation of interpretation of the differences in promiscuity between the sexes is to be found in correlations showing that promiscuity among the males was not significantly related to socially deviant behavior while it was so related among the females. It should come as no surprise that promiscuity correlated significantly with venereal disease, especially among the boys.

Exploded Stereotypes

Although nonwhites accounted for 71 percent of the universe, Puerto Rican teenagers, 16 percent, and other whites, 13 percent, promiscuity was found in all three groups with no essential difference. Contrary to a prevailing stereotype, the white teenagers were the new residents in the city. A majority of the nonwhite and most of the Puerto Rican patients were either long-term or lifetime residents of the city. In some instances physicians in the clinics failed to inform white teenagers about the research interview, and these were not, therefore, included in the study.

A majority of the young people interviewed came from low-income, minority group families. However, only one-sixth were dependent, in part or in whole, on public assistance. More than one-sixth of them came from families of lower middle-class status, and 28 percent from families with middle-class aspirations. Their social class status was confirmed by the home visits and by indices of parental control. For example, over two-thirds of the teenagers reported that their parents were interested in knowing where they went, expected them to be home at a certain time, and set standards for their behavior even if unable to insure that these were carried out at all times.

The stereotype of demoralized families with little potential for rehabilitation does not stand up under the study's findings. Most of the parents who were interviewed expressed concern over the behavior which had resulted in their child's illness, though often they did not seem to know about other socially deviant aspects of his or her behavior. The social worker who interviewed parents in their homes encountered requests for help and many evidences of a desire to improve their situations. For example, there were many indications of attempts to transform slum apartments into attractive, livable homes.

More than three-fourths of the teenagers interviewed—79 percent—were over 16 years of age; 62 percent were 18 or 19 years old. In religion, 62 percent were Protestant; 32 percent were Catholic; 2 percent were Jewish; the remainder were either unaffiliated or belonged to miscellaneous religious groups. Almost half the young people reported that their parents attended religious services, while slightly more than 25 percent of the teenagers themselves did so.

The educational and cultural levels of most of these young people can only be characterized as impoverished. While nearly 75 percent had entered high school, only 15 percent had graduated. Few reported any use of New York City's neighborhood libraries and the cultural opportunities available in the schools and in community centers. However, 3 percent were attending college.

The major school problems reported were lack of interest in subjects, reading difficulties, failure to achieve promotion, and lack of interest on the part of the teachers. As one teenage girl put it: "My teacher would sometimes say, 'I get paid whether you learn or not. I don't have to teach you!'" This

girl, like many of the other teenagers, had been involved in truancy before becoming involved in sexual activities. Repeated truancy was reported by 80 percent.

Of the 439 teenagers not in school when interviewed, only 176 had had any work experience, part or full time.

The teenagers revealed their concerns over lack of a meaningful role in answers to questions designed to get at their self-image. When asked what they did in their spare time, 509 replied: "Nothing!" This is not in contradiction to their having indicated that they spent some time in recreational and other types of activities—including sexual; it is a frank—if somewhat devastating self-appraisal. Having nothing to do—in the sense of having few meaningful and socially useful responsibilities—means essentially to be nothing. To what extent this lack of role and the resultant *anomie* may be related to promiscuity can only be raised as a question for further investigation.

Social Controls and Behavior

Despite the availability of techniques for mechanically processing research data, relating social controls to behavior is still a major problem for the social sciences. The status of today's knowledge of human behavior and its interaction with environment calls for caution in interpreting statistical associations, especially in an exploratory study. Because of this and the subjective nature of interview data, probability levels were set high in the tests for statistical significance, and reservations were made in the interpretation of correlations.

Many of the indices of social control generally regarded as having an influence on behavior reflected significant relationships to promiscuous and socially deviant behavior, with variations according to sex and ethnic group. Among these indices were: psychological atmosphere of the home (rated as favorable if the teenager spent considerable time there, took his friends there, and did things with his family); teenagers' religious attendance; whether or not the teenager lived with his family; and whether or not the teenager was still in school. School status reflected the most statistically significant influence.

Attempts at classifying the teenagers as living in a "favorable" or "unfavorable" environment were unsuccessful, since most of them lived in environments having both favorable and unfavorable aspects.

Educational level correlated significantly with what was rated as a very good knowledge of the facts about venereal disease. However, only 10 percent of the young people had this kind of knowledge—not surprising in the light of the generally low level of educational attainment.

Despite their involvement in sexual activities these young people exhibited little understanding of the meaning of sex. Peers constituted the source of sex knowledge for 64 percent of these young people, while parents were the source for 21 percent; other adults, for 15 percent. Relatively fewer of the teenagers who obtained their sex knowledge from parents or adults with whom they had a positive identification were promiscuous.

Ignorance is transmitted with the same ease as knowledge. At some point the cost of the transmission of ignorance has to be weighed against the cost of improved education for parents and professional persons, as well as for teenagers.

While many of the teenagers had been involved in "delinquent" behavior, the group as a whole could not be characterized as delinquent. More than half the young people reported they had driven cars without a license and had done some stealing; 27 percent had been involved in street fighting; 38 percent had come to the attention of the police; but only 7 percent had been taken to court.

The interviewers were impressed with the frankness with which the teenagers revealed illegal actions and other aspects of their behavior that did not present them in a favorable light. They were also impressed with the frequent expressions of guilt and religious conflict.

Some Contrasts

The difficulties in establishing a typology for differentiating these teenagers, their general ignorance about sex and venereal disease, and the wide range of their behavior, both social and sexual, suggest the need not only for more education but also for greater individualization of these teenagers. Consider the contrasts in the following young people who were among those interviewed in the social hygiene clinics:

A shy, withdrawn, guilt-laden honor student of 18, who lives with his grandmother, had his only sexual experience with a prostitute to test his "virility."

An 18-year-old drug addict, who lives with both parents, has had at least 25 sex partners toward whom he feels no personal attachment. He feels sorry only for having been "caught."

A highly intelligent high-school girl, who lives with both parents, had infrequent sexual relations with her steady boy friend, but caught syphilis from him after he had impulsively had relations with a "pickup," following a lover's quarrel.

A recent arrival in New York, where she has no family ties, has gradually drifted into prostitution.

A 17-year-old girl from a closely knit family, who was goaded by her girl friends into having sexual relations with her fiance, found herself both pregnant and infected, and is in an anguish of guilt and fear for the future.

A 15-year-old boy from a broken home and a special school for problem children became infected from engaging in homosexual activity for money. He says he has no goals, does not care about anyone, and had no idea what he wants out of life.

One need all these young people had had in common was for better education about sex and venereal disease. On the surface, this should present little or no problem. The issue is, however, beclouded by emotionally charged, conflicting, and controversial attitudes toward sex in society at large, as well as among the teenagers who have contracted the disease. Constructive sex education requires a point of view and sanctions for codes of behavior to which society expects its youth to adhere. Such education should not only help to prevent the behavior which results in infection but should facilitate cooperation from the young patient in the contract interview and prevent repeated infection. It can only succeed, however, if ways can be found to involve such youth in opportunities for more education generally, the cultural life of the community, and, above all, in meaningful work and social responsibility.

Whether these implications are soundly based will, in the near future, be a matter of objective report. As a result of the study, an adolescent clinic has been initiated in the health center in which the exploratory interviewing took place. A social worker has been assigned to provide counseling and make referrals to rehabilitation agencies, and plans are underway for the provision of psychiatric services, a youth employment counselor, and courses in family life education. Moreover, even before the study was completed, changes in attitude were discernible among those responsible for operating the social hygiene clinics.

It is good to see these beginnings in a period during which it has become fashionable to emphasize man's potential for evil and to assume that control of the sex drive during adolescence is not only not essential to mature development but impossible to achieve. Teenagers like those in the study have been held responsible for conduct traceable to the failure on the part of adults to facilitate and sanction controls. Twentieth-century psychological theories that have been exploited to support sexual license, almost to the debasement of human values and personal relations, need to be reexamined if followup studies and the experimental clinics confirm the findings of this study.

In 1947 Dr. Stokes warned that even a perfect cure would not eradicate the venereal diseases since "their onset is often obscure, often invisible and nonincapacitating," and that "conduct not treatment is the key to control." [3] It is hoped that this study may stimulate more attention to the social aspects of venereal disease without which efforts at control are undermined. Stokes' warning and Scheele's statement more than a decade ago that "what is needed is increased research on the part of those in psychiatry and the social sciences to determine the factors underlying the spread of venereal infection and the social deviations related to their spread," [4] are even more pertinent today.

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[1] Deschin, Celia S.: The relation of socioeconomic and cultural factors to an understanding of illness, Ph. D. dissertation. Center for Human Relations and Community Studies, New York University, 1958.

[2] Deschin, Celia S.: Teenagers and venereal disease; a sociological study. American Social Health Association, New York. March 1961. Reprinted by the U.S. Department of Health, Education, and Welfare, Public Health Service, Communicable Disease Center, Venereal Disease Branch, Atlanta, Ga.

[3] Stokes, John H.: The course in health and human relations: its origin and its purposes. *Educational Outlook,* January 1947.

[4] Scheele, L. A.: We are moving forward. *Journal of Social Hygiene,* March 1949.

It is necessary for the physician to provide not only needed treatment, but to provide for the sick man himself, and for those beside him, and to provide for his outside affairs.

—*Hippocrates*

Placements of children regarded as unadoptable prove there are . . .

ADOPTION OPPORTUNITIES FOR THE HANDICAPPED

ALICE HORNECKER

Child Welfare Supervisor
District 6, Missouri Department of Public Health and Welfare, Mexico, Mo.

DOES the social work principle, "Every child has a right to a home and a family that loves and wants him for himself," include the severely physically handicapped or mentally defective child?

Present attitudes in our culture toward such children (referred to hereafter as "special" children) are much more positive than they were even a few decades ago. In the distant past children with severe defects were hidden, ridiculed, and tortured. Romans and Greeks destroyed them without feeling guilty or remorseful. Even in countries where there were more humane attitudes, such children often aroused feelings of hostility or fear. Unfortunately, remnants of these negative feelings toward the severely handicapped are still present in most of us. It took some actual experiences to help me overcome my own feelings about placing such "special" children for adoption. Until child welfare workers can be helped to recognize and overcome their negative feelings about severely handicapped children and can believe firmly that every child is entitled to a home, they will not go far in attaining this goal.

A "special" child has the same basic needs as every other child. First of all, it is important to remember that he is a human being with needs, feelings and lovable and unlovable characteristics. Second, it is necessary to view the abnormal conditions realistically, not through pity or hopelessness, but with sympathy and compassion. Next, every possible resource should be called upon to help the child become as presentable and as near normal as possible. Only as child welfare workers have the knowledge and the courage to discuss the problem of homeless, handicapped children clearly, will the general public develop enough of a knowledge of it to lead to the uncovering of many potential resources for their care. Unfortunately, however, when a diligent search needs to be made for adoptive parents who have that "plus quality" required for accepting a handicapped child and helping him develop to his maximum capacity, some workers do not really believe that there are people who have the capacity to welcome and cope with these "special" children. Yet experience has shown that a hopeful resource for adoptive parents for such children lies in carefully selected foster parents who in their efforts to help the child overcome his handicaps might learn to love him and want him as their own.

Several experiences have convinced me that adoptions should not be ruled out for severely handicapped children.

Jimmy

First, there was Jimmy, born after an extremely difficult delivery. Soon after his birth, Jimmy's mother, who was considered to be mentally retarded, was told that her child had suffered brain damage

and could not be placed for adoption as she and her parents had requested. Jimmy was placed in an oxygen tent and remained in the hospital for 5 months, until he was taken to a nursing home where he stayed, receiving custodial care only until he was 2½ years old. Then he was brought to our public child welfare agency's attention by one of his relatives, who was concerned about him. When the child welfare worker first saw him she was shocked and heartsick. The child was pale, listless, and completely unresponsive. He made a queer babbling sound, but could not talk. He evidently had not had any solid food, as he did not know how to chew. His gait was staggered and he ran into objects. Later it was discovered that he could not see farther than a foot. His head was unusually large; there was a squint in one of his eyes; his teeth were small, stubby, and separated; and he was pigeon breasted. He commanded attention by beating his head on the floor or by having temper tantrums.

The child welfare worker arranged for Jimmy to have a complete physical and psychological examination. Testing indicated an IQ of 36, with a diagnosis of obvious mental and physical retardation. Adoption certainly did not seem feasible at this point.

Jimmy was placed in a carefully selected foster home where he could experience love, as well as good physical care. The foster parents were a farm couple who were happy and secure and who had an unusual capacity for loving a child. They were frankly told about his problems and were asked to observe this extremely neglected child closely and to give him every chance to develop.

After only 3 days of tender loving care, this sad, apathetic child began to respond to his foster parents. He rewarded them with his first smile and began taking some interest in his surroundings. The foster parents received their first clue to his potentialities when they noticed that he observed what was going on around him and imitated readily. He soon learned to say "mamma" and looked to the foster mother to supply his needs.

Gradually the foster parents' initial feeling of pity began to change to love and pride in his progress. They had many discouragements during the first few months, but they never even considered giving him up. Neighbors made disparaging remarks. Their family physician frankly told them the child was not normal and advised them to return him to the welfare office before they became too attached to him. When the doctor's attitude became known, the child welfare worker persuaded him and the foster family to refer the child to a well-known pediatrician.

This pediatrician deserves much credit for Jimmy's eventual progress. He was hopeful from the first and gave generously of his time, talking with and encouraging the foster parents. He has said that, if Jimmy had remained in the nursing home another 6 months, he would probably have died of marasmus.

Convinced that Jimmy had possibilities, the child welfare worker supported the foster parents in all their efforts, helped them evaluate his progress, and gave them many helpful suggestions for handling specific problems.

After an eye specialist fitted him with glasses, Jimmy immediately learned to walk better, to explore, and to act more normally. This provided further indication of his potentialities. Later he underwent a double hernia operation, a tonsillectomy, and an adenoidectomy. All of these corrections helped to improve Jimmy's general health and disposition, and further strengthened the child welfare unit's conviction that probably he would become adoptable.

Six months after Jimmy's placement in their home, the foster parents petitioned for legal custody. From then on there was no question—Jimmy had found a permanent home. He was tested by the pediatrician and a school psychologist. This time his IQ was in the low normal range. Both examiners predicted he would be able to attend regular school.

Jimmy was legally adopted by his foster parents just 2 years after he had been placed in their home. Fortunately, he had been originally placed in a boarding home which might later be approved as an adoptive home, so that replacement for adoption was unnecessary. This, no doubt, would have caused regression.

Jimmy is now a happy, secure child. He runs and plays like a normal child and is well behaved. He still has a slight speech impediment, but has a good vocabulary and is very inquisitive. He has a retentive memory, likes books, and has learned to write his name. He was 7 years old in March and is now attending school. The only reason he did not attend kindergarten or nursery school, was that there were no such facilities in his community. His foster parents have also adopted a little girl, and the two children are very congenial.

Manny

Manny is another child that once seemed to be unadoptable. He was born with a congenital heart condition. He underwent open-heart surgery for

banding the pulmonary artery and has since been in and out of the hospital several times. The doctor, who admitted him the last time in February 1961, said that he probably would not live very long.

Manny had been removed from his own home under court action because of neglect. He was weak, listless, and wheezed when he breathed. Placed in a good foster home after discharge from the hospital, he, too, responded to the patient, loving care of his foster parents. After 3 months in the foster home, he was walking and talking quite well, was toilet trained, and seemed happy and secure. His physical condition has improved to such an extent that now there are no restrictions on his activities. As in Jimmy's case, Manny's foster parents have fallen in love with him and have already petitioned to adopt him.

Mack

Another entirely different type of handicapped child is Mack who was born without legs. Otherwise he was a healthy, attractive baby. His parents were so horrified by his handicap that they refused to take him home from the hospital. He was placed in a boarding home with a foster mother who had previously been told about his condition, who was not shocked when she saw him, and who had the capacity to love him for himself. Arrangements were also made, through the State Crippled Children's Service, to take him to the Amputee Center in Grand Rapids, Mich.,[1] where after two visits he was fitted with a prosthesis.

Mack's first prosthesis was a plastic bucket which fit his hips and was fastened to a dolly so that he could move about with the aid of crutches. His sturdy body, strong arms, and a strong spine were assets in using this walker, which he loved because it enabled him to go places.

Mack is now 3 years old. At the age of 2 he was fitted with artificial legs, and he quickly learned to walk.

Mack is a happy child and has such an outgoing personality that he readily sells himself. He learned to talk early, could feed himself before he was 2, and was partially toilet trained. His desire to be independent was an asset in motivating him to use the artificial legs he will always need.

Fortunately there were foster parents who would accept Mack and who helped develop a better understanding of handicaps in their entire community. Some of their neighbors changed from attitudes of horror and ridicule to over-solicitousness. Others, as soon as they were exposed to the foster parents' and worker's enthusiasm and optimism, accepted him wholeheartedly. The State Crippled Children's Service, the Missouri Society for Crippled Children, the county court, and the child welfare services of the Division of Welfare, State Department of Public Health and Welfare, contributed both money and service to meet Mack's needs.

On one of our trips to the Amputee Center with Mack, the child welfare worker and I learned that two of the most severely handicapped, but apparently happy, children we saw there had been adopted. One of them had been born not only without legs, but also with a severe mouth deformity. When he was born, his lower jaw, lips, and tongue were fused together. They had to be separated by surgery before he could swallow, chew, or talk.

This child, now 8 years old, is able to walk and run well on his artificial legs without the use of crutches. His mouth is still deformed, but he can talk audibly and eat solid foods. Never have I seen a happier child or prouder adoptive parents. They told us that he had done more for them than they could ever do for him and that they had no regrets for the many hours spent in taking him to clinics

This is Mack, born without legs and deserted by his parents, but now happily established in the home of adoptive parents.

and in teaching him to use his prosthesis, nor for the money they have spent on him and will need to continue to spend to help him develop to his maximum capacity.

This convinced us that somewhere there were parents for Mack, too. The next step was to obtain accurate diagnoses of both his mental and physical potentialities. Then efforts were made to find a permanent home for him.

When he was 2 years and 4 months old, Mack was placed for adoption with a couple who when they had applied for a child had not thought of a handicapped child but who, the worker sensed, had that "plus" quality needed by parents of the handicapped. She arranged for them to meet Mack and he readily sold himself to them.

Mack's adoptive parents realize the responsibility they are assuming in accepting this permanently handicapped boy as their own, but they have no qualms about it. Aged 35 and 31, they have a son of their own aged 12. They live in a small town of 1,500 people, where Mack has already endeared himself to their friends and neighbors.

Attaining the Goal

Unfortunately there is still much disregard for the value and rights of every individual, regardless of his condition. Who can predict which child may make the greatest contribution to society and which one is "worthy" of being helped? One of the doctors at the Amputee Center was a double amputee—as was the man who made the prosthesis. What a loss to society if they had been cast aside or neglected because of their handicaps!

Not long ago a 13-year-old boy who was born without legs was presented the St. John Ambulance Life Saving Award for saving a friend from drowning. A 10-year-old North Dakota boy, born without hands or feet, was named the 1960 National Easter Seal Child. This boy, with the use of artificial legs and hands, plays baseball, shoots marbles, is a Cub Scout, and receives better than average grades in school. Many severely handicapped children, if given a chance, can become self-supporting, responsible citizens. This "chance" involves receiving not only correction of their defects insofar as possible, but also the tender loving care and security of a home of their own.

In order to attain what should be our goal, *a home for every child who is free for adoption*, further attention needs to be focused on effective ways of achieving this goal. Briefly, in planning for a child with a severe handicap or an undiagnosed serious illness—it is well to select foster parents who might adopt, but it is important to let them understand clearly from the first that adoption may or may not be possible.

Potential adoptive parents should be involved in helping the child to become adoptable. They may grow to love him during his period of helplessness and dependency. The younger a child is placed, the more readily will he be acceptable and responsive.

The child should always be honestly presented, but not oversold. Foster parents should not be made to feel they are expected to adopt the child. Neither should they be made to feel guilty if they have done all they can and the child does not respond, or it is found that their home does not meet his needs. If the child sells himself to the foster parents, if the worker is convinced of the high quality of love and care given him, and if the foster parents ask to adopt him, their wish to do so should be given serious consideration.

The "Child Welfare League of America Standards for Adoption Service," states:

> **Consideration should be given to supplementing the income of families that have the essential qualifications to meet the needs of children for whom there are insufficient homes, but whose income is too low to assume the full cost of care of a child. In this way children who might otherwise never be placed for adoption might be given the emotional security of legal adoption at no greater cost to the community than for long-time boarding home or institution care. A new group of applicants might be reached who do not apply because of limited income. Some boarding home parents to whom a child has become attached might be able to adopt him if financial support were continued.[2]**

In following these standards, goals must always be realistic. All community treatment resources available must be put to use in meeting the "special" child's needs. In planning for these "special" children, the child welfare worker should not only possess professional skill, but an abundance of courage, imagination, faith, and initiative. Backed by these qualities, efforts expended for "special" children can succeed.

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[1] Frantz, Charles H.: Child amputees can be rehabilitated. *Children*, March–April 1956.

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How questions of function and social change affect . . .

PROFESSIONAL EDUCATION FOR PEDIATRIC NURSING

DOROTHY E. JOHNSON

Associate Professor of Nursing
University of California Medical Center, Los Angeles

EFFECTIVE EDUCATION for practice in any professional field is related to two interdependent and crucial factors: the functions the profession serves in society, and the nature of the problems faced by the profession because it has these functions. Both of these factors are influenced, in turn, by significant changes in the world in which we live.

Because nursing's functions have never been clearly delineated, educational programs in nursing have had to be based in large measure on assumption.

There are a number of current views about nursing's functions and the nurse's appropriate areas of activity. The discrepancies in these views account, at least in part, for differences in educational programs and in the expectations of practitioners of nursing, and for some existing confusion about what nursing is. Some persons regard nursing as a skill rather than as an applied science, an academic discipline, or a profession. Among these people are some registered nurses, physicians, basic scientists, and many academicians. Many physicians tend to believe that nursing consists solely of delegated activities in medical care, though some will concede that public health nursing is somehow different. Many nurses, hospital administrators, and medical sociologists think registered nurses should function primarily in managerial and supervisory positions where they are responsible for the business management of units of health agencies and for the supervision of auxiliary personnel who provide the nursing service.

In recent years, however, a growing and increasingly more vocal group of nurses have begun to question the movement of the nurse away from the patient and nursing practice toward administration and the provision of medical care.

The nursing educator stands among these conflicting views and is forced to crystallize her own system of beliefs and assumptions about nursing as a profession and about nursing's functions. The form and characteristics of the educational program will depend upon this system of beliefs and assumptions. Therefore, any discussion about the preparation of the pediatric nurse must be prefaced by an explanation of the specific assumptions underlying what is to be said.

I assume that nursing is evolving as a learned profession and an academic discipline. The emphasis in the educational program, therefore, must be on knowledge and its use conceptually as well as practically, and not on rules or methods in practice. I also assume that nursing can and does make a contribution to society through direct service to patients, and that this contribution is distinct from, though related to, the contribution made by the medical profession.

I believe that nursing's primary function is concerned with care rather than cure, with giving the individual support under his present circumstances

and helping him to cope with the health problems he faces. Appropriate nursing action of this kind is not simply a skill to be learned or mere human kindness. Such action cannot depend upon common sense or intuition. It requires scientific knowledge of high order. I believe this to be true of all nursing and especially of pediatric nursing.

Some people speak disparagingly of care as an insignificant component in nursing. Others who grant that care is important will not grant either that care activities do or might have a basis in science, or that they might be an important focus of professional activity, in spite of the increasing knowledge in the psycho-physiological and the socio-psychological fields which shed light on the kinds of care that patients need. Nevertheless, the burden of proof as to the significance of care as nursing's primary function, and the scientific bases for care activities in nursing, must rest on the field of nursing.

Education for professional practice in pediatric nursing begins at the undergraduate level. The basic program offered at this level is a generic one designed to produce a competent, generalized nursing practitioner—a nurse who can function effectively with people of all ages, sick or well, acutely or chronically ill. Such a program must provide a sound and reasonably broad basis in knowledge, sufficient to enable the future practitioner to cope adequately with the common nursing problems which she will meet in caring for patients. Offerings in the humanities, a rich background in the natural and social sciences, and appropriate content and practice in nursing are essential components of the program.

The graduate of this program is prepared to offer nursing service to adults or children in a hospital, a public health setting, or a school. She is not prepared to recognize or handle all of the nursing problems with which she might be confronted. Her knowledge is greater than her skill in the use of knowledge. She has been trained, however, to observe carefully, to think in conceptual terms critically and analytically about her observations, and to seek help when it is needed.

The nurse who continues her study at the graduate level may decide to concentrate on the field of pediatric nursing. If she does, she will be expected to extend her knowledge in this field and increase her competency as a practitioner. The subject matter of nursing studied at the graduate level does not necessarily differ in kind from that considered at the undergraduate level. The difference in graduate study is the focus on selected aspects of the subject matter and the exploration of these aspects in depth and breadth.

The graduate student supports her advanced study of nursing through continuing study in one or more of the natural or social sciences. She is also expected to consider the limitations in knowledge in the field and to prepare herself systematically to extend the knowledge available. The graduate student may also study in a functional area, equipping herself with the knowledge and tools for teaching, consultation, supervision, or higher level administration.

Questions of Focus

The two major questions for both levels of education are: *what knowledge is needed?* and *for what purposes?*

Striking changes have taken place in the kind and the character of childhood health problems listed in morbidity and mortality reports and cited in the literature, and such changes will undoubtedly continue. Childhood diseases of great importance in years past have disappeared or have been controlled. New medical diagnoses have appeared on the scene. The kinds of behavior problems for which parents seek help seem to have changed; masturbation, for example, no longer appears to concern parents as greatly as questions of child-parent and parent-child relationships. The conception of what constitutes a health problem has been broadened to include such social problems as juvenile delinquency.

Whether these changes represent a basic change in the problems of interest to the health professions, and particularly to nursing, is open to question.

The professions exist to serve man in society, and they have tended to be oriented to the practical problems which man faces. Health problems have been identified through empirical observations and the bodies of knowledge in the professions have been largely empirical. With some notable exceptions, only relatively recently has there been a general move in the health professions toward blending empirical knowledge with conceptual explorations which seek to explain and predict.

Similarly educational programs in nursing traditionally have been focused on the practical problems which patients face or might face. Students in pediatric nursing, for example, have been taught the symptoms, pathology, medical therapy, and nursing care for a wide range of diseases treated as discrete entities. They have been taught about the common behavior problems of children, such as lying or enuresis, in much the same manner. The normative

approach has been used in teaching growth and development; that is, that children walk and talk at certain ages, are ready for toilet training at a certain time, and so on. Graduates of such programs have been ill prepared for changes in the nature of the practical problems with which they are confronted. Moreover, the limited knowledge provided has encouraged circumscribed thinking and action.

It is possible, with the knowledge now available through work in many disciplines, to delineate and organize in nursing courses knowledge of a higher level of abstraction and generalization which is relevant to many of the practical problems the child and his family experience. Knowledge of this order might be developed around what could be called conceptual problem areas to distinguish this approach from the practical problem approach.

Conceptual Problem Areas

These conceptual problem areas can be divided for purposes of discussion into two major categories: developmental and care-of-the-sick.

The developmental category is composed of problem areas which are related to the human processes of maturation and socialization. They have to do with the growth and development of a child and a family in a given community and culture. Some of the problem areas in this category are: maternal behavior and maternal role learning, affection and affiliative behavior, fetal-newborn physiological adaptation, oral behavior, excretory behavior, dependence-independence, aggression, achievement, sexual behavior, reproductive behavior, and physical-physiological growth cycles. Knowledge offered in nursing courses centered on these problem areas would consist of a synthesis of knowledge drawn from many fields and an extension of this knowledge when possible. Course work in child psychology, and in the physical, emotional, and social growth and development of children, would be a prerequisite to undertaking this course work in nursing.

The care-of-the-sick category consists of problem areas which have to do with illness, injury, or defective development. Problem areas within this category have relevance for disease processes or psychosocial malfunctioning, for medical or nursing diagnostic and therapeutic procedures, for institutionalization, and for the immediate and long-term effects of these factors on maturation and social development. The identification of problem areas within this category is made more difficult by nursing's responsibilities in medicine, for some of the problem areas of necessity represent primarily the medical interest. The list of problem areas within this category might include: affectional deprivation, invasion of privacy, depersonalization, rest and sleep, sensory deprivation and social isolation, oxygen deprivation, restrictions in movement or in food and fluid intake, fear, pain, and the like.

The problem areas listed in these two categories are not all of the same order, nor can they all be treated on the same conceptual level. There is also overlapping within and between categories. Such a listing might be helpful, however, in providing the framework needed for the development of an integrated body of subject matter basic to nursing practice. The undergraduate student would be introduced to essentially the whole scope of knowledge of the nature suggested here in 2 to 3 years.

The graduate student in pediatric nursing would concentrate on selected problem areas, depending on her interests, the body of knowledge available, and the significance of the area in practice. She might, for example, explore sensory deprivation in proseminar and seminar nursing courses while adding to her understanding of this phenomenon through continuing work in neurophysiology and social psychology. The knowledge and understanding thus acquired would add immeasurably to her ability to cope with the problems presented by children who are blind or deaf or have eye surgery, who are confined to respirators or spend long months immobilized in casts or traction, or who are hospitalized for days or weeks or months with a minimum of human contact or interaction or of variation in the physical environment. Such study should also provide a basis for systematic investigations about sensory deprivation, in order to establish a scientific rationale for nursing assessment and intervention.

The conceptual problem areas suggested here obviously are not the exclusive interest or concern of the nurse, but are also of interest to members of other helping professions as well as scientists in several disciplines. The configuration of knowledge in these areas offered in training would differ in the various professional programs, according to the purposes for which knowledge is needed, the content of the nursing courses depending on the nurse's function.

The Uses of Knowledge

If nursing's contribution to society is made through direct service and is the outcome of care, as I believe it should be, the educational program must prepare the prospective pediatric nurse with the knowledge

needed for direct service in defending, supporting, and assisting children and their families in the health-illness complex. If society's need for nursing of this kind is to be met, the majority of professionally prepared pediatric nurses must be allowed and, indeed, encouraged to remain direct service practitioners. This will be possible only if health agencies are sufficiently reorganized to permit business management to be delegated to persons other than nurses and to provide for recognition of increasing competency in nursing practice.

It will always be necessary to draw some nurses, prepared at the graduate level, from direct practice to serve as teachers, consultants, administrators, and full-time research investigators. It is important for these nurses, with the possible exception of the researchers, to find ways to maintain and improve their competencies as practitioners in the field, since their effectiveness in the communication of knowledge and the improvement of practice will depend heavily on their own competencies in practice.

Nurses to carry out the teaching, consultant, administrative, and research functions of nursing are in short supply, and their numbers must be increased. The profession, however, has an obligation to find ways of utilizing their knowledge and skills more effectively. New teaching tools and techniques, a different view of clinical practice, and increased recognition of the student's responsibility for learning may be of help in alleviating the teacher shortages. Consultants and administrators who are relieved of peripheral duties by auxiliary personnel so that they can focus their attention exclusively on nursing may be able to extend their services further.

Nurses prepared at the baccalaureate level for direct service to patients are also in short supply, and determined efforts must be made to increase the number of senior college students enrolled in nursing programs. Such efforts will not be successful, however, unless educational programs in nursing are intellectually exciting and personally satisfying, and unless the potential rewards of practice promise to be comparable to that in other professional fields. Marked changes will be necessary in many educational programs and in almost all nursing services if recruitment efforts are to succeed.

Shortages in other categories of nursing personnel may be more apparent than real since current organizational and operative patterns in nursing services often do not allow the best possible utilization of personnel. An orientation to tasks, fixed routines, categorical activity assignments, and the like may serve industry well, but such patterns in health agencies can only lead to patient dissatisfaction and inflexibility in the use of personnel. Careful study in this area is essential.

The pediatric nurse who has a sound grasp of the wide range of knowledge suggested here should be able to provide the kind of environment and learning experiences in her interactions with parents and children which will assist and support them in coping with the problems the child meets in growing up. The nurse cannot change the world in which the child lives or control his unique human experiences, but she can and should have the fullest possible understanding of that world and the parents' and child's relationship to it. Such knowledge and understanding should enable her to see beyond the practical problems being presented, and should provide a sounder basis for the service she offers. More important, it should prevent her from hasty and ill-conceived intervention in the form of rules, advice, and prohibitions.

In care of the sick, with emphasis on *care*, the well-prepared pediatric nurse is in a position to help prevent much of the psychological stress and trauma associated with illness and hospitalization today. Equally important, she can help lessen the patient's physical and physiological distress, preventing complications and enhancing the effectiveness of the medical regimen.

The nurse, who, at the graduate level, has acquired the needed theoretical basis of pediatric nursing should contribute much to future developments in the field. As a growing number of these nurses are found in organizations offering direct service to patients, they can provide the needed model and stimulation for change in other personnel, study problems in nursing assessment and intervention, develop new methods, and raise questions to be explored conceptually and subjected to systematic investigation.

Educational programs in nursing today are developing a new orientation. There is an increasing respect for knowledge and a greater understanding of what competent practice in a profession involves. There is a growing appreciation of the limitations and the potentialities of the field. There is a sounder approach to teaching and learning. Nursing is reaching toward maturity, academically and professionally.

WHO ARE THE UNMARRIED MOTHERS?

ELIZABETH HERZOG

Chief, Child Life Studies Branch, Division of Research, Children's Bureau

IN his recently published book, "Unmarried Mothers,"* Clark Vincent has cast new light on an old question: Who are the unmarried mothers?

Throughout the years, different answers have been offered to this perennial question. There has hardly been a time in this century when it has not been considered important and when some answer has not had wide currency—usually naming a specific group as the one from which *the* unmarried mother comes.

It is sensible and practical to be concerned with this question. The answer is important in itself and also as a clue to *why* there are unmarried mothers. A clue, however, is only a clue. The "who" in itself may not reveal the "why," even though it is a prerequisite to discovering the why.

There is a double need to know as much as possible about who the unmarried mothers are, and why. For one thing, misunderstanding of the causes is likely to block improvement. For another, prevailing assumptions about the who and the why (whether correct or incorrect) will determine how problems resulting from illegitimacy are viewed, and what the society is willing or able to do about them.

The prevalent answer to the recurrent question has varied from year to year, although there are always dissenting minorities. And the answer given most credence at the moment is what chiefly influences professional practice and public policy.

Clark Vincent presents the answers typical of different decades in brief sketches, further condensed (and oversimplified) here:

The period	*Emphasis on—*
Before 1930	"Inborn" immorality, bad companions, mental deficiency
During the 1930's	Environmental sources of behavior (poverty, broken homes)
Late 30's—early 40's	Culture, life ways
The 40's—early 50's	Psychological and psychiatric explanations
Mid- and late 50's	The sick society

Vincent's summary (as he gives it) brings out, not only the changing emphases, but also the fact that each successive theory was documented by reports of the particular kind of unmarried mothers that would confirm it. Conceivably, radical changes in the population of unmarried mothers have occurred, and unmarried mothers were in fact more likely to be mentally below par before 1930 than later. But beyond doubt, the generalization of the moment, as it changed from year to year, was based on lopsided samples.

Therefore, as Vincent comments, "much—if not most—of the existing data about unwed mothers may tell us less about factors contributing to illegitimacy than about the clientele of given charity

*Vincent, Clark: Unmarried mothers. The Free Press of Glencoe, New York, 1961. 308 pp. $6.

institutions, social agencies, outpatient clinics, and physicians in private practice."

On the encouraging side, recent research has shown renewed interest in social-environmental aspects, without relinquishing interest in psychological and psychiatric aspects. There is always a danger of chronological snobbery in claiming that today we are less naive than the investigators of 50 years ago. Actually, some investigators of 30 years ago were saying what so proudly we hail today as the birth of new wisdom. The difference, however, is less in what is said at any moment than in what is heeded. And today there does seem to be somewhat more readiness than before to accept multifaceted theories about who the unmarried mothers are, and multifaceted speculation about why. If there is indeed such a change, no one has contributed to it more directly and substantially than Clark Vincent.

A Challenge to Stereotypes

The three-part study woven into the book is directed toward the key question: who are the unmarried mothers? The refreshing part of this effort is the refusal to settle for the captive-audience approach that has so long distorted our picture of unmarried mothers, and accordingly has warped our ideas about possible causes and cures of problems relating to illegitimacy. Dr. Vincent's findings challenge a number of single-factor theories about illegitimacy. His data come from a county hospital, maternity homes, and 500 physicians in private practice. The private patients, especially, challenge the picture of *the* unmarried mother as immature and dependent—physically, psychologically, and socially. They tend, on the average, to be older than the unmarried mothers found in maternity homes or social agencies, and to be economically and psychologically more self-sufficient. A careful study of national statistics would at least confirm Vincent's picture of chronological age, for a majority of unmarried mothers (60 percent) are 20 or over, even though a majority (68 percent) of unmarried women of childbearing age (14–44) are under 20.

As Vincent points out, research has neglected the college-educated unwed mothers employed in white collar and professional jobs, and between 20 and 29 years old.

The lack of information about this particular *age group* is inconsistent with the estimated national increase of over 300 percent in their illegitimacy rate between 1938 and 1957 (as compared with the 108-percent increase among 15- to 19-year-olds); but it is consistent with the fact that many of them do not represent a social problem in the usual sense. . . . These women are likely to travel incognito from their own State to another, where they are attended by physicians in private practice, live independently during pregnancy, and have their medical expenses paid by couples to whom they release their children for adoption.

This is the group whose out-of-wedlock pregnancies are most likely to go unreported.

It is seldom that empirical findings, theoretical considerations, and recommendations for practice are as effectively blended as in this book. On all three levels the material is thoughtful, thought-provoking, and well stated. Yet it is the empirical findings (and the planning behind them) that give the book the characteristics of a breakthrough. One may accept or reject the theoretical discussion—though much of it would be hard for this reviewer to reject. One may accept or reject the recommendations on services for unmarried mothers—and apparently some practitioners do quarrel with some of them. But one can only applaud and be grateful for the investigations reported and for the way they are interwoven with the findings and theories of others and with the available national figures and estimates.

Persons concerned about illegitimacy should be grateful, for the refreshing realism of the questions asked, the ingenuity and unpretentiousness of the means for answering them, the library research that enriches them, and the scrupulous qualification, where qualification is due.

True, the gratification may somewhat resemble the gratification of the emperor when the little boy finally convinced him that he was not unfit but merely undressed. Dr. Vincent's findings raise questions about a number of opinions that sometimes parade as fact. As he points out, the studies reported here will require replication before they can be extended to sweeping generalizations. However, even before further investigation, they cut the ground out from under certain generalizations that appear with considerable frequency, including the following:

- The unmarried mother is immature and dependent.
- The unmarried mother is typically a product of a broken home.
- The higher illegitimacy rates among nonwhites are due primarily to ethnic and cultural factors.
- Pregnancy out of wedlock is a symptom of emotional disturbance and/or disturbed family relations.
- Relations between unmarried parents are for the most part of a fleeting and casual nature.
- The unmarried father's relation to the unmarried mother is exploitative.
- Financial considerations determine the unwed mother's choice of an adoption outlet.

As has been said ideas about the causes and cures of illegitimacy are greatly influenced by ideas about who the unwed mothers are. They are influenced also by ideas about the setting that has produced the unwed parents and their offspring. Like some other investigators before him, Vincent finds a good deal to condemn in the complex of social sanctions that encourages illicit coition and censures illicit pregnancy, while welcoming the product of illicit pregnancy (if a healthy white baby available for adoption) and occasionally giving the unmarried mother better breaks than the married mother.

Vincent is stern in his insistence that efforts to understand and help those whose behavior violates our social norms should be balanced by efforts to understand and help those whose behavior supports legitimate marriage and family life. He adds that far less research, attention, and money are expended in behalf of those whose behavior conforms to social norms than in behalf of family failures. And he observes that we must expect to live with the consequences of the values we manifest through our actions rather than of those values which we proclaim with words.

IN THE JOURNALS

Institute for Judges

The origin and first year's offerings of a 10-week institute for juvenile court judges inaugurated at the University of Minnesota in the summer of 1961 are described by the director of juvenile delinquency programs of the university's Center for Continuation Study, in the April issue of the quarterly, *Crime and Delinquency*. ("A Training Course for Juvenile Court Judges," by Eugene H. Burns.) Financed by a grant from the National Institute of Mental Health, the institute was attended by 17 judges, most of them from small communities in Minnesota or elsewhere, who received a stipend for living expenses.

The author reports that the judges spent the first 3 days of each week attending classes, making field trips to social agencies and institutions, and in local juvenile court operations, and returned to their home communities for the rest of the week. The classes focused on juvenile court law, principles of child growth and development, factors contributing to delinquency, the prevention and treatment of delinquent behavior, communications and public relations, and organization and administration of the juvenile court.

The author presents a set of qualifications, based on the opinions of institute participants, for effective juvenile court judges: training in law; an ability to accept differences in others and to base decisions on the long view of things; and willingness to work with other persons and agencies in combatting juvenile delinquency.

He regards the institute, which is being given again this year, with some modifications, as a step in the direction of Sheldon Glueck's proposal for development of a separate profession of juvenile court judges.

Care at Midway

For the emotionally disturbed adolescent—who is "midway between the natural dependency of childhood and the independent status of adulthood"—a day-care psychiatric treatment program has the advantages of providing more flexibility and less stigma than hospitalization, and at less cost, and more constant and intensive supervision than outpatient services, according to Harold W. Pfautz in the April issue of the quarterly, *Mental Hygiene* ("The Functions of Day-Care for Disturbed Adolescents").

Describing a day-care project operated by the Butler Health Center in Providence, R.I., for disturbed adolescents whose illness blocks them from finding or holding work or from continuing school, the author, a co-director of the project, describes the different points at which this care entered the patients' treatment histories. In short case illustrations, he shows the various functions of the program as furnishing: a direct alternative to hospitalization; an intermediate service; rehabilitation after inpatient treatment; a refuge and followup after hospitalization; and a testing ground for treatment in hospitals with which it alternates.

Research Cul de Sac

"We are maneuvering ourselves into a cul de sac in respect to significant data relating to infancy," contends psychologist Bettye M. Caldwell, research associate, College of Medicine, State University of New York at Syracuse, in the April issue of the *Merril-Palmer Quarterly of Behavior and Development*. ("Assessment of Infant Personality.")

One of the reasons she cites is the reliance in infancy studies on "unsampled samples" of neonates in hospitals, a practice that leaves informational lacunae about events in middle and later infancy which may be critical for personality theory. Therefore, she finds predictions about personality traits based on data from such newborns "a bit presumptuous at this stage of our knowledge."

Investigators show experimental timidity in setting up research situations especially in the case of infants, the author maintains, saying this has led to much use of secondhand methods of data gathering. She also charges investigators with being preoccupied only with those problems that are tied to psychoanalytic theory—particularly with what she calls the *ignes fatui* of socialization theory: feeding, weaning, and toilet training. The fact that em-

pirical findings have litle effect on psychoanalytic theory, she says, creates a situation in which theory and research are not fulfilling their obligation of mutual nourishment.

Dr. Caldwell suggests that research workers study the infant in learning situations and in his natural habitat, and that they carry on personality studies with methods and parameters that reflect the biosocial approach.

Challenges in Public Health

With advice to the public health worker to keep his mind open to new ideas, Myron E. Wegman, M.D., dean of the University of Michigan School of Public Health, charts some new areas of public health concern in the May issue of the *American Journal of Public Health*. ("Organization for New Responsibilities in Public Health: Part I—Health Needs and Trends.") The paper is one of a group in this issue from a symposium presented at the 1961 meeting of the American Public Health Association.

Modernizing Hippocrates' concept of disease as related to air, water, earth, and fire, the author refers to the shrinking resources in the first three of these "elements," and to the increasing danger of burns or equally harmful penetration from ionizing radiation. He also sees public health challenges in the indiscriminate use of therapeutic agents and in problems derived from the growing number of human beings. While praising advances in genetics, he warns against the tendency to regard man as "a chain of organs and conduits," on which are engrafted emotional problems, instead of a totality of emotional and physical strengths and weaknesses.

The effectiveness of a public health agency, the author says, is directly related to the degree in which it encompasses factors in the social environment that affect health and well-being.

In another article ("Medical Care") from the same symposium, Martin Cherkasky, M.D., director of Montefiore Hospital in New York, maintains that the quality of medical care available in a community should concern public health schools and agencies, since it has great impact on the health of the community. He cites examples of what organized consumer groups have done to bring about improved medical care.

Family Process

The first issue of a new semiannual journal, *Family Process*, published by the Mental Research Institute of the Palo Alto Medical Research Foundation and the Family Institute "to foster a development of a science of the family," appeared in March of this year. This first issue devotes its entire content to various aspects of treating schizophrenia through the family treatment process. (See "Family Study and Treatment," by Nathan W. Ackerman, CHILDREN, July–August 1961.)

Films on Child Life

FEEDING THE NEW BABY. 13 minutes; sound; black and white; loan.

Demonstrates the preparation of the formula, washing, and care of nursing equipment; stresses the need for warmth and tenderness while feeding the baby.

Audience: Prenatal and maternity classes.

Produced by: The Kendall Co.

Distributed by: Association Films, Ridgefield, N.J.

CHILDREN IN THE HOSPITAL. 44 minutes; sound; black and white; purchase.

Depicts the spontaneous activity of children (4- to 8-year-olds) on the wards at Boston City Hospital and illustrates how they respond emotionally to the stress of illness, hospitalization, and separation from parents; presents some of the mental health implications of the experience and phases of hospital life as the child sees it; and points up the kinds of support offered to the children by specialized staff and others.

Audience: Doctors, nurses, social workers, and psychologists; and also, with a professional discussion leader, selected lay groups.

Produced by: Edward A. Mason, M.D., with the cooperation of the Harvard School of Public Health, National Institute of Mental Health, Boston University School of Social Work, and Children's Mission to Children.

Distributed by: International Film Bureau, Inc., 332 South Michigan Avenue, Chicago 4, Ill. In Canada: Educational Film Distributors, Ltd., 577 Jarvis Street, Toronto 5, Canada.

A MORNING FOR JIMMY. 28 minutes; sound; black and white; purchase or loan.

Tells the true story of a Negro high school boy who encounters employment discrimination because of his race, and whose feelings of frustration are nourished by his father, a trained bookkeeper who works as a red cap. The boy's high school teacher encourages him to seek further education and training by taking him to meet several Negroes who are successful in varied technical and professional occupations.

Audience: Civic groups, students, PTA's high school teachers, counselors, employers, and general public.

Produced by: The National Urban League, N.Y.

Distributed by: Association Films, Ridgefield, N.J.

WHERE CHILDREN COME FIRST. 28 minutes; sound; rent or purchase.

Presents the varied program of the National Congress of Parents and Teachers in its efforts to cope with the needs of children in such areas as parent education, health supervision, safety education, and guiding adolescents in planning a code of behavior.

Audience: PTA's, civic groups, women's clubs, and meetings of mental health societies.

Produced by: Dallas Jones Productions, Inc.

Distributed by: The National Congress of Parents and Teachers, 700 North Rush Street, Chicago 1, Ill.

BOOK NOTES

CHILDHOOD SCHIZOPHRENIA. William Goldfarb. Harvard University Press, Cambridge, Mass. 1961. 216 pp. $4.50.

The author has culled, in this book, the fruit of several years of enquiry into what distinguishes schizophrenic children from normal children and what differentiates the subclasses of schizophrenia from each other.

He reports on testing a group of children referred as schizophrenic to the Henry Ittleson Center for Child Research, which he directs, describing the emergence of two etiologic clusterings among the children: the "organic," or brain-damaged, who might be simply mentally deficient in another family environment; and the "nonorganic" whose condition reflects the interplay of family psychosocial dynamics and the child's ego competence.

Two chapters devoted to these subclusters point to the general superiority of the "nonorganics" over the "organics," especially in overall adaptive and functional competence.

Having found many more among the schizophrenic group in the organic class than the usual neurological test had indicated, the author argues for the sharpening of the diagnostic criteria through careful descriptions of pathological phenomena over long periods. He maintains that the direction should be towards assaying (1) the adequacy of the child's physiological basis for receiving and evaluating impressions and conceptualizing and acting; and (2) the adequacy of the child's psychosocial milieu for ego development.

HEALTH SERVICES FOR MOTHERS AND CHILDREN. Helen M. Wallace, M.D. W. B. Saunders Co., Philadelphia, Pa. 1962. 466 pp. $10.

"Health Services for Mothers and Children" is a textbook written for public health personnel of many disciplines who are involved in the health care of mothers and children, either in organizing or administering programs or in giving direct services. The historical development, the organization of care, and the trends in health services for mothers and children are traced. The author has divided her subject matter into the following sections: maternity and newborn period; child care, including growth and development of children, health supervision, school health and hospital care; services for children with various handicapping conditions; other special services such as foster family care, day care, and homemaker service.

Two chapters, "Emotional Growth and Development of Children" and "Effects of Separation of the Child From His Family," were written by Dr. John A. Rose.

Although there have been significant accomplishments in improving the health of mothers and children, according to the author, there are many remaining problems and unmet needs such as the failure to reduce perinatal mortality and to lessen the incidence of disability among surviving infants. The author also discusses ways of closing the gap between what is known and what could be done to bring additional health benefits to mothers and children. Throughout the book are lists of activities which should be a part of official health agency programs for mothers and children: for example, steps which could be taken to prevent pregnancy wastage, especially among women with a previous complication or unfavorable outcome of pregnancy.

THE PSYCHOANALYTIC STUDY OF THE CHILD. Ruth S. Eissler, Anna Freud, Heinz Hartmann, Marianne Kriss, editors. International Universities Press, New York. 1961. 563 pp. $8.50.

As in earlier volumes of this annual series, the editors unfold a broad sampling of contemporary theory on personality development, infused with clinical material from direct observation and treatment of children.

The book's 25 papers are in three parts. The first, comprising contributions to psychoanalytic theory, opens with a preliminary report of a study of the psychological processes in pregnancy and of the earliest mother-child relationship. Also included are papers on the development of symbolic thinking and on the roles of libido and aggression in the development of pathology. The second part, on aspects of normal and pathological development, contains, among others, papers on the development of the blind, integration of psychic structures, adolescent psychic structures, the role of verbalization in early childhood, and the effects of deprivation on institutionalized infants.

Included in the final group, on clinical contributions, are reports on the treatment of a blind child, on behavior disorder and ego development in a brain-injured child, and on the emotional sequelae in a 6-year-old Yemenite girl, of an operation for cataract.

MENTAL RETARDATION. Proceedings of the Association for Research in Nervous and Mental Disease, December 11–12, 1959, New York City. Williams and Wilkins, Baltimore. 1962. 331 pp. $15.

The 23 papers in this volume offer a multifaceted look at intellectual inadequacy, whether from organic defect or from social or environmental interference. With focus on findings of recent investigations, the contents cover five broad areas: the developmental process; genetic factors; prenatal defects; neonatal injuries; environmental deprivation; and treatment.

CUMULATIVE INDEX TO NURSING LITERATURE, 1956 to 1960, Volumes 1–5. Edited by Ella J. Crandall and Fumiko Oiye. Glendale Sanitarium and Hospital, 1509 East Wilson Avenue, Glendale, Calif. 1962. 913 pp. $20.

1961 January–June Supplement. 1962. 84 pp. For two semi-annual parts, $10 to subscribers or $12.

Synthesizing five annual cumulative lists of the nursing literature into a single volume, the 1956–60 index contains over 34,000 references to items in 17 nursing journals, arranged alphabetically first by author, then by subject, and then cross-referenced.

The supplement for January–June 1961 is the first of a planned series of semiannual cumulations which indexes articles from 23 periodicals including some hospital and medical journals.

HERE AND THERE

Peace Corps

By the middle of June 1962, after 15 months of operation, the Peace Corps had 3,000 volunteers serving overseas or in training, about one-third of whom were women. The average age of the men was 24 and of the women, 25; 42 were under 20 years of age and 6 were more than 60 years old. Peace Corps volunteers were working in 16 countries in Asia, Africa, and Latin America. By September 1962, more than 4,000 volunteers are expected to be overseas or in training here.

All of the 12 countries in which volunteers were stationed as of March 1 had requested more; and 20 other countries had asked for volunteers.

This summer Peace Corps volunteers will depart for 28 projects, the majority of them concerned with education, agriculture, health, and community development. In a project in Honduras, 12 graduate social workers will direct casework, supervise community organizing, and teach; 2 child-care workers will supervise a day-care center and a residential center; and 14 nurses will work in hospitals and health centers.

In October, a Corps-sponsored international conference will be held in Puerto Rico to discuss the pressing needs in developing countries for the kind of manpower the Peace Corps has concentrated on sending: persons with "middle-level skills"—somewhere between the unskilled, and the top-level specialists offered in other aid programs.

Meshing Efforts

Scores of public and voluntary agencies are cooperating with the Peace Corps, helping to recruit volunteers, lending skilled technicians, and providing equipment and facilities for its projects, and, in some instances, helping to administer them.

The State Department, parent agency of the Corps, before approving a Peace Corps project, evaluates it against a background of other American activities in the area, then serves as a reservoir of area information and advice at each stage of planning, development, and operation, and furnishes administrative support and guidance in the field. The Peace Corps also draws information from the State Department's Agency for International Development (AID) from the U.S. Information Agency and from the Office of Education, Department of Health, Education, and Welfare. AID also gives administrative backstopping to the Peace Corps in countries where both have missions. In this case, when the two agencies work in the same program, they dovetail their efforts at different levels—as, in malaria control in Thailand where AID gives specialized advice to top officials of the health ministry, and Peace Corps laboratory technicians work alongside their Thai counterparts. Or the agencies work in different phases: Liberia's schools which received substantial assistance from AID are now partially staffed by Peace Corps teachers, who, in some cases, substitute for local teachers being further trained through AID.

The Department of Agriculture, besides advising the Corps on how to deal with farm communities and furnishing technical information, has arranged, through its Federal Extension Service, for representatives in each State extension service to act as sources of recruiting information. Other Federal departments furnish the Corps with mailing lists that have potential for supplying applicants in desired fields.

The Public Health Service has detailed about 25 physicians to the Corps. Together with four volunteer physicians working in rural health clinics in Togo, these doctors comprise the Corps medical staff, with duties that include surveying proposed project sites to estimate the health needs of volunteers, arranging for health care of volunteers, and when possible, giving volunteer help to the host countries' medical programs.

In a pioneer try at United Nations-Peace Corps collaboration, the Food and Agricultural Organization is expected by August to have 3 Corpsmen working in an animal health project in Malaya, and later 20 in irrigation work in East Pakistan. Corpsmen were also expected to join projects of UNESCO, the International Civil Aviation Organization, and the U.N. Technical Assistance Program.

Among voluntary agencies that will be directing Peace Corps projects overseas, as of August 1962, are: the National 4-H Foundation, with 43 volunteers developing 4-H work in rural communities in Brazil, and a similar number in Venezuela; the Near East Foundation, with 47 volunteers in vocational agricultural teaching in Iran; the Young Women's Christian Association, with 20 Corpsmen in a public housing project in Chile—teaching, among other things, child care and personal hygiene; CARE, with more than a hundred in Colombia, working in community development, welldigging, and building sewers and roads; Heifer, Inc., with 15 Corps volunteers in St. Lucia and 59 in Ecuador doing agricultural extension work; the Agricultural and Technical Assistance Foundation, with 10 volunteers teaching agriculture in Thailand and 22 doing rural youth work in Sarawak; the Experiment in International Living, with 20 volunteers in Pakistan helping to build a model community; and International Voluntary Services, with 30 volunteers developing rural schools in Liberia.

Educational institutions are also administering Peace Corps projects: Notre Dame University, in Chile; Colorado State University, in West Pakistan; and Michigan State University, Harvard University, and the University of California at Los Angeles, in Nigeria. A project to be initiated in the Somali Republic in August will be directed by New York University.

The Groundwork

Besides serving as bases for recruiting volunteers—about 1,600 major colleges have liaison workers furnishing information about the Corps to potential applicants—some 43 universities have been taking part in volunteer training, which is now in three phases: the first is typically pursued in universities in this country; the second, mainly physical and mental conditioning, is carried out for most volunteers in Rio Abajo, a mountainous region in Puerto Rico; and the third is carried out in the host area, using educational facilities there.

Last March the Corps, collaborating with the three universities in Puerto Rico, launched a program to make that island a center for the first two phases of training for volunteers slated to serve

in projects stressing self-help in community development, largely in Latin America.

Guided by the Peace Corps-Puerto Rican Policy Board, composed of representatives of the University of Puerto Rico, the Inter-American University, and the Catholic University of Puerto Rico, this program gives the Corps access to the pooled resources of the universities and several Commonwealth departments of government. Studies in community development comprise 8 weeks at one or more of the universities, plus 6 weeks of actual work in the field under the guidance of one of the Commonwealth departments. The first contingent of its trainees, 21 destined for rural development work in the Dominican Republic, will be followed by 101 volunteers for community development projects in Peru and Ecuador, and 56 for a nutrition program in Peru.

A similar consortium of universities in and near Washington, D.C., was also formed to help plan and carry out Peace Corps training in the Capital area. This group, called the Inter-University Peace Corps Policy Board, includes Johns Hopkins University, George Washington University, American University, Catholic University, Howard University, Georgetown University, and the University of Maryland.

—Eleonora Chatty

Joint Conference on Children and Youth

Finding ways to create opportunities for youth to achieve a more responsible role in society was the focus of concern at the Joint Conference on Children and Youth, held in Washington, April 10–12. The fifth joint conference to be sponsored by the National Council of State Committees for Children and Youth, the Council of National Organizations for Children and Youth, and the Federal Interdepartmental Committee on Children and Youth, this was the first to be held since the 1960 White House Conference on Children and Youth and the first to involve the co-sponsorship of the National Committee for Children and Youth, the followup coordinating body created by that conference. Attending were 442 members of the sponsoring agencies' constituent organizations, including 57 young people of high school or college age.

The young people participated along with the adults as speakers, panelists, and roundtable discussants. As in the White House Conference, they called repeatedly for chances to prove themselves by being given more responsibilities and being allowed to make their own decisions. As Mary Helen Worthy, teenaged president of the Oklahoma Youth Advisory Board, put it at the opening session: "We can meet our own responsibilities if we know what is expected of us."

The importance of youth participation in community affairs was stressed in almost every session. But one young panelist, asking "what about the Freedom Riders?" said he resented the implication that the youths of today are not interested in public affairs. Others referred to the success of the Peace Corps as evidence that young people are eager to serve their fellow men, and asked about the possibility of a "domestic Peace Corps" being created for service in needy areas at home.

One young man said he felt that the young people who are chosen for conference participation are not the ones who need this kind of experience the most. "Somehow," he told the conferees, "you are going to have to find a way to give this kind of experience to every young person." And a young girl suggested: "Why not a parent-teacher-youth organization?"

But there were some participants—adults and youth alike—who warned against putting too much pressure on youth, already pressed with school work and peer activities. One participant asked: "Must young people be forever scheduled and organized, lest they become creative?"

Ways adults and adult organizations could help youth to find themselves and their place in society were suggested by Roy Sorenson, general secretary of the YMCA of San Francisco, in a keynote address referred to repeatedly during the conference. (See page 131.)

During part of the conference the Council of National Organizations and the Council of State Committees offered separate programs. The former presented panels of adults and of youths to discuss their respective responsibilities to create "experience opportunities" to help youth achieve social goals; and a report of an inquiry into opinions about the White House Conference, which indicated that individual reactions depended largely on experiences in the work groups. Robert Bondy, director of the National Social Welfare Assembly, urged national organizations to create volunteer service opportunities for young people, to encourage them to engage in social action, to include them on adult planning bodies, and to press for the formation of youth councils.

The Council of State Committees offered a "clinic" for new or reorganized State committees and a day-long program devoted to discussion of citizen responsibility in the legislative process, with members of both Houses of Congress participating. Rabbi Robert J. Schur of the Beth El Congregation, Fort Worth, Tex., advised agencies to lay aside their vested interests "for a super-oriented goal"—the welfare of the community as a whole.

Some areas of "unfinished business" in following up the recommendations of the White House Conference were identified at the conference's banquet by Arthur S. Flemming, former Secretary of Health, Education, and Welfare, as: racial desegregation of schools, services, and housing; the creation of greater public appreciation of public welfare programs; improvement in education, especially through Federal aid. At the closing session Ellen Winston, North Carolina State Commissioner of Public Welfare, said that the specialists in work for children and youth must become social reformers to see that *all* children and youth be provided opportunity for maximum development, regardless of the sins of their parents.

—K. C.

Federal Legislation

Provisions for training young people for job opportunities are contained in the Manpower Development and Training Act of 1962, signed by the President on March 15. The act, to be administered by the Secretary of Labor, authorizes a 3-year, $435 million program to train the unemployed and upgrade the underemployed—after study of the Nation's manpower requirements and resources. Training under the act is to be carried out under the aegis of the Secretary of Health, Education, and Welfare through agreements with State vocational education agencies, the trainees being referred by the Secretary of Labor, who will retain direct responsibility for on-the-job training.

In regard to training youth, the act reads, in part: "Whenever appropriate,

the Secretary of Labor shall provide a special program for testing, counseling, and selection of youths 16 years of age or older, for occupational training and further schooling."

Trainees 19 through 21 years of age may be paid training allowances at a rate of up to $20 a week, where such allowances are necessary to furnish them occupational training, provided that not more than 5 percent of the estimated total training allowances for the year be paid to this group. Youths 16 to 19, though eligible to apply for training, are not eligible for these special allowances.

Unemployed youths over 16 who have had 3 years of gainful employment and are the heads of families or households may, under the act, be eligible for the regular training allowances spelled out in the act's general provisions for unemployed trainees of all age groups—allowances based on each State's average weekly unemployment compensation benefits.

The Secretary of Labor is placing emphasis on the selection of untrained and inexperienced youths, such as school dropouts and other unemployed, out-of-school youth in urban areas, particularly in metropolitan areas; rural youths who need further academic or vocational preparation to qualify for jobs; and high-school graduates, including college dropouts, for whom further schooling is necessary to obtain suitable employment.

Effective July 1, the act provides for Federal financing of training costs and training allowances for the unemployed for the first 2 years and 50 percent of the cost of training employed persons, and, for the third year, financing all costs on a 50–50, State-Federal matching basis.

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To stimulate expansion of educational television, Federal funds up to a total of $32 million for a 5-year period have been authorized for helping States and local agencies to defray the cost of constructing such broadcasting facilities, through legislation passed by the 87th Congress and signed into law May 1. Under the act, the Secretary of Health, Education, and Welfare may make grants on a 50- to 75-percent matching basis, to State or local education authorities, and State, nonprofit, or State-supported organizations concerned with educational television. Grants in any one State may not total more than $1 million. Primary responsibility for planning facilities are left with the States and local organizations.

Up to the start of May, out of the 279 channels set aside for education by the Federal Communications Commission, only 62 had been used. FCC officials estimate that from 110 to 140 new stations may be activated as a result of the bill.

For Youth

With a major emphasis on developing opportunities for youth, the President's Committee on Juvenile Delinquency and Youth Crime recently made the first eight grants under the Juvenile Delinquency and Youth Offenses Control Act of 1961. (See CHILDREN, November–December 1961, p. 233.)

Three of the grants will help finance the planning of demonstration projects to mobilize community resources for all-out attacks on juvenile delinquency. This planning will involve study of the sources of the delinquency and design for programs to provide opportunities to youth in such areas as employment, family services, education, and recreation. The awards were: $124,228 to the Greater Cleveland Youth Service Planning Commission; $260,582 to the University of Houston; and $155,825 to Community Progress, Inc., New Haven, Conn.

Only one demonstration grant was awarded $1,915,000 to Mobilization for Youth, Inc., New York City, for a 3-year demonstration of a community-oriented approach to prevention of juvenile delinquency in the lower East Side.

Four grants were made for training persons who work with youth: $182,181 to Southern Illinois University to help develop a training center for personnel working with delinquents, giving courses of up to 16 weeks for teachers, judges, law enforcement officers, and social workers; $12,074 to a New York school district for a 2-week summer institute at a treatment institution, Hawthorne Cedar Knolls, to help 25 educators start or improve school programs for delinquent or emotionally disturbed youngsters; $109,200 to Hunter College for 2 years of developing and evaluating material and procedures for training teachers working in schools with large numbers of deprived children; and $36,990 to the National Federation of Settlements and Neighborhood Centers for two 6-week courses at Hull House in Chicago, each for 20 youth workers.

The grants were made by the Secretary of Health, Education, and Welfare, in consultation with the Secretary of Labor and the Attorney General, upon the recommendations of the technical review panels. The Demonstration Project Technical Review Panel examined and made recommendations on 65 planning and demonstration project applications, while the Training Program Technical Review Panel considered 32 training program requests. The former were judged for comprehensiveness of the envisioned project, wide involvement of public and private agencies, local financial commitment, and built-in mechanisms for evaluation. Training grant applications were judged on the basis of the training institutions, comprehensiveness of teaching resources, proximity to demonstration areas, a willingness to share costs, and other factors.

A new Youth Development Unit, recently established in the Children's Bureau, will provide the grantees with technical assistance. Shelton B. Granger, formerly executive director of the Urban League of Cleveland, has been appointed its Director, and Mary E. Blake, recently consultant on community services in the Bureau's Division of Juvenile Delinquency Service, as Assistant Director.

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During the past 3 years in the city and county of Dallas, the Texas State Departments of Public Welfare and Health, interested individuals, and numerous local business, civic, service, and religious organizations have contributed to the support of the Dallas County Youth Study Project, a comprehensive study of the community's services for youth which has involved the participation of every local youth-serving institution or agency in the community as well as of a number of State, Federal, and national voluntary organizations.

The study was undertaken in September 1959 by the Dallas Council of Social Agencies at the request of the Juvenile Welfare Federation, an association of 70 civic clubs and organizations, which raised $50,000 for the project from business organizations and citizens. With the threefold purpose of evaluating current services, recommending new services where needed, and

suggesting ways of increasing the effectiveness of existing services, the project has eight major sections, each under the auspices of a subcommittee of an overall citizens committee which makes the final recommendations to the community.

Already completed are studies of police services, the county industrial school for boys, and the courts and detention facilities. These were conducted by consultants from the Children's Bureau and from the National Council on Crime and Delinquency. Also completed are studies of social services for children in their own homes and in foster care, conducted by staff from the Child Welfare League of America with consultation from the Children's Bureau and the State department of public welfare, and financed by child welfare service funds. Other completed studies were: of special school services, conducted by a private outside educational consultant; of group work and recreation services, conducted by the staff of the concerned agencies with consultation from the United Community Funds and Councils of America; of church services, conducted by a private consultant; and of expenditures for various areas of service, conducted by the Council of Social Agencies.

Still underway is a study of health services, being financed and conducted by the maternal and child health division of the State department of health with consultation from the regional staff of the Children's Bureau, and from a team of outside consultants who are experts in maternal and child health, psychiatry, dentistry, and school health.

All of the studies provide a blueprint for the agencies and for community planning. In some instances the participating agencies have already carried out the study recommendations.

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Two pilot projects to study the best methods for helping to find jobs for unemployed, out-of-school youth were launched in late March in St. Louis, Mo., and Newark, N.J., by local public employment offices of the respective State employment services, with the assistance of the U.S. Employment Service and the employment divisions of the State agencies. Testing remodeled job-finding and placement programs for young people, the projects are expected to yield information on occupations with job openings for inexperienced young workers; the extent of unemployment among different age groups; the charactertistics of hard-to-place youngsters; hiring channels and factors determining job choice; the kinds of additional training needs; and problems associated with the migration of rural youth to cities, in addition to other data. They are slated to continue at least until July 1963.

WHC Followup

The National Committee for Children and Youth has recently released two publications concerned with followup of the recommendations of the 1960 White House Conference on Children and Youth: "Patterns of Organization of State Committees for Children and Youth," which describes the various characteristics, status, and functions of such committees and presents a model organization pattern, and is available at 65 cents a copy from the Superintendent of Documents, Government Printing Office, Washington 25, D.C.; and "Social Dynamite," the report of the Conference on Unemployed, Out-of-School Youth in Urban Areas, held in Washington in May 1961 (see CHILDREN, July–August 1961, page 151), containing background material, summaries of the proceedings, and the complete text of the speech by James B. Conant, available at $2 a copy from the National Committee for Children and Youth, 1145 19th Street, N.W., Washington 6, D.C.

Child Welfare

During May, the Children's Bureau allocated a total of $218,335 for 16 projects approved during that month under its program of research and demonstration grants in child welfare. The grants, the first under the program, were made on the recommendation of a 9-member advisory group following the review of 42 applications. (See CHILDREN, May–June 1962, page 123.) The selected projects will be carried out by public or nonprofit agencies and institutions in 10 States.

The grants are in two categories: (1) those for projects approved in much the same form as proposed in the application; (2) those to help the applicants to do more detailed planning within the framework of their projects and to tool up and test the proposed projects through pilot studies. Seven projects were approved in the first category and a total of 9 in the second category.

Among the 16 selected projects were studies or demonstrations focusing on: the relationship of social and cultural environment and the child's mental growth; followup of older children and their adoptive parents; the use of a college's resources to meet the needs of culturally deprived preschool children and their families; the provision of post partum casework to unmarried mothers; the selection of foster parents for disturbed children; the effectiveness of group work for teenagers and their parents in one-parent families; the relationship of institutional philosophy, practice, and structure to the restoration of family living for the child.

Additional applications, for which the deadline was June 1, will be acted upon in the fall.

Mental Retardation

Deployed in 6 task forces since the first of this year, the 27 members of the President's Panel on Mental Retardation (see CHILDREN, January–February 1962, page 33) met in Washington, March 13 and 31. Under discussion was the progress made by these groups in their search for new pathways to prevention and treatment of mental retardation, through their respective fields of inquiry. These were: prevention and clinical and institutional services; education and rehabilitation; law and public awareness; biological research; behavioral research; and coordination of community services for the mentally retarded.

Among the issues discussed were the relative weight of cultural as against biological factors in mental retardation; how to bridge the gap between research findings and clinical practice; the need to consider the residential center as only one of several treatment resources; the value of medical schools collaborating with residential centers for the mentally retarded in their teaching programs; and the need to revise educational materials and curriculum for the mentally retarded to look toward preparation for employment.

In April, 17 members of the panel, forming three foreign missions, spent 3 weeks studying community programs, residential care, and special education for the retarded in England, Sweden and Denmark, and the Netherlands.

The chairman, Leonard Mayo, and vice chairman, Dr. George Tarjan, with the assistance in two cities of Mrs. R. Sargent Shriver, special consultant to the panel, held hearings in San Francisco, Los Angeles, Denver, St. Louis, Seattle, Atlanta, and Providence, R.I., in which they listened to more than 200 persons—from some 30 States—representing mainly parents' organizations, citizens' groups, State and local agencies, and university research staffs. Subjects highlighted included parent counseling, day-care centers, State and Federal aid for special education, and public attitudes toward mental retardation.

At a meeting in June with Mrs. Shriver, Mr. Mayo, and Dr. Tarjan, the task force chairmen presented their final reports and recommendations. These will be synthesized and, together with findings of the regional and foreign surveys, submitted to the President in September.

About Vaccines

The first licenses for manufacturing Type 3 oral polio vaccine were issued by the Public Health Service to two pharmaceutical houses in late March. With the licensing of Type 3, all of the oral vaccines needed for protection against the three types of poliomyelitis can now be sold in this country. (See CHILDREN, March–April 1961, page 77.) At the same time, the Service released recommendations on the use of polio vaccines for controlling poliomyelitis during the 1962 season, based on reports of the Surgeon General's Advisory Committee on Poliomyelitis Control.

The Service urged that persons inadequately protected in 1962 receive a complete series of either inactivated (Salk) or live (Sabin) vaccine. Named among priority uses for the vaccines when supplies are limited, was immunization of the highly susceptible infant and pre-school-age groups of children, of which, as pointed out in the statement, over 65 percent have not been adequately protected.

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About 400 children in Upper Volta in Africa have been immunized safely and effectively with live measles vaccine, according to the report of a pilot study carried out recently by the National Institutes of Health. The study was designed to ascertain whether the vaccine, administered safely to some 10,000 children in this country, would be equally safe for the children in West Africa, who live in different environmental conditions. The disease has been reported to kill 25 to 50 percent of the children in Upper Volta during the first few years of life, as compared with 0.01 percent in this country.

The project, undertaken on the request of the Upper Volta Government, is aimed at establishing the clinical safety of the vaccine before considering its large-scale use in developing countries. Vaccinations were begun November 19, and included a 2-week surveillance period that ended January 10. Ranging in age from 7 months to 3 years, the children were without previous history of measles. Serologic tests of blood samples taken prior to vaccination and 4 weeks later showed that 94 percent of the children had actually been susceptible to measles, and all developed antibodies.

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A collection of seven papers on live measles vaccine—recent clinical, laboratory, and epidemiologic findings—is offered in a supplement to the February 1962 issue of the *American Journal of Public Health*, published by the American Public Health Association. Written by epidemiologists of the Public Health Service, research investigators, and pediatric faculty members of several universities, the papers discuss the importance of measles not in "total days disability or number of deaths, but rather . . . human values and . . . the fact that tools are becoming available which promise early control and early eradication." They also evaluate and report on pilot studies carried out with the live attenuated measles vaccine.

Price, $1.50 (with the February journal), from the Association, 1790 Broadway, New York.

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This spring the National Institute of Allergy and Infectious Diseases set up a Board for Vaccine Development composed of four physicians from the Universities of Colorado, North Carolina, and Illinois, and Cornell University, and two research scientists of the Institute. In late April, the Board signed a 1-year contract with Pfizer & Co., Inc., for the development of vaccines against a number of agents that are the major causes of respiratory diseases popularly called the "common cold." This contract is the first of a series that the Board will award to industrial research organizations and universities and other medical centers.

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In mid-April, tests of a vaccine against trachoma were started by the Public Health Service in a pilot study involving 400 children in Indian boarding schools in Phoenix, Ariz. Trachoma is still a major problem in this country only among the Southwest Indians.

Training for MCH

A conference on the teaching of maternal and child health in graduate schools of public health was held in Minneapolis early in March under the joint auspices of the Children's Bureau and the American Public Health Association's Committee on Relationships Between MCH Faculties in Schools of Public Health and MCH and CC Field Services—the MCH and CC standing respectively for "maternal and child health" and "crippled children's" services.

Working papers for the conference were prepared on the basis of questionnaires circulated among the schools of public health and visits to 14 of these schools by representatives of the APHA committee. Among the general topics to come under scrutiny were: current status, trends, and prospects of MCH services; personnel needs; the relationship of MCH to clinical medicine; MCH teaching in the general public health curriculum; teaching of MCH specialists; research needs; and provisions for continuing education. A committee is now preparing a full report of the conference.

In mid-April a report, prepared by a steering committee of MCH faculty members who were participants at the conference, was presented at the annual meeting of the Association of Schools of Public Health in Ann Arbor, Mich., by Dr. Samuel M. Wishik of the University of Pittsburgh. Among other points, it stressed the following:

- As the gap widens between population size and numbers of health workers, health workers and departments will have to make difficult choices among the demands they face and find new ways to increase their efficiency.
- One of the major weaknesses in the MCH field is the scarcity of obstetricians in public health.
- Sound public health administration,

"MCH or otherwise," requires a solid basis in clinical medicine.

• Every school of public health should have on its full-time faculty at least one physician specializing in MCH, paid from regular school funds.

• MCH program content and problems should be used as material to illustrate a wide variety of basic public health concepts.

• A fellowship program tying together public health education and clinical training is needed to attract young physicians to the MCH field.

• The MCH component in the school's curriculum should be divided between didactic and field experience.

• The school should provide sufficient MCH personnel to help strengthen the public health program in the surrounding area and to give interpretations to students in their field-work.

• Methods should be found for providing a full year of school-supervised residency training in MCH after completion of the school program.

• The teaching of MCH should be carried out by a faculty which is strongly interdisciplinary in character.

• Refresher institutes might be offered on a nationally coordinated basis under the joint sponsorship of the schools of public health and field agencies.

At its annual meeting the Association of Schools of Public Health adopted a resolution urging the Children's Bureau to provide financial support for fellowships for 3 or 4 years of MCH training and experience, designed to attract pediatricians or obstetricians into careers in public health.

Guides and Reports

ENDS AND MEANS OF URBAN RENEWAL; papers from the Philadelphia Housing Association's 50th Anniversary Forum. Philadelphia Housing Association, 1717 Sansom Street, Philadelphia 3. 1961. 102 pp. $2. Free to members of the Association.

Presents seven background papers dealing with the human and physical aspects of urban renewal and methods of carrying out a comprehensive urban program; and a synthesis of the discussions and papers from the Forum.

VISION SCREENING IN SCHOOLS; recommendations of the National Society for the Prevention of Blindness. National Society for the Prevention of Blindness, 16 East 40th Street, New York 16. Publication P257. 1961. 12 pp. 10 cents.

These recommendations for a program to identify school children with impaired vision first appeared in *The Sight-Saving Review*, Vol. 31, No. 1, Spring 1961.

SERVICES FOR CHILDREN WITH EMOTIONAL DISTURBANCES: a guide for public health personnel; prepared by the Committee on Child Health of the American Public Health Association. The American Public Health Association, 1790 Broadway, New York 19. 1961. 120 pp. $2.50.

One of a series dealing with services to handicapped children, this guide discusses the symptoms and extent of emotional disturbances in children; their causes and means of prevention; case finding; principles of diagnosis and treatment; the community services, professional personnel, and organization required for providing treatment; and trends in research.

CONCEPTS OF PREVENTION AND CONTROL: THEIR USE IN THE SOCIAL WORK CURRICULUM. Council on Social Work Education, 345 East 46th Street, New York 17. 1961. 32 pp. $1.

A report of a 3-day workshop attended by social work educators and practitioners.

TERMINATION OF PARENTAL RIGHTS. Mildred Arnold and Vallie S. Miller. Children's Division, The American Humane Association, 896 Pennsylvania Street, Denver 3, Colo. 1961. 14 pp. 15 cents. Quantity discounts on request.

Two papers on the safeguards needed to protect the rights of children and parents in termination proceedings and the principles behind these.

EDUCATION FOR SOCIAL WORK; proceedings of the ninth annual program meeting, Council on Social Work Education, Montreal, Canada, February 1–4, 1961. The Council, 345 East 46th Street, New York 17. 1961. 182 pp. $5.

Includes papers reflecting the meeting's emphasis on: (1) restructuring of the social work curriculum; (2) implications for social work education in community planning, development, and organization; and (3) the professional manpower shortage in social work.

ENURESIS. Dr. Barnardo's Homes, National Incorporated Association, 18–26 Stepney Causeway, London, E. 1. 1961. 26 pp. 1 shilling.

Three papers which deal with the causes and effects on children of bed wetting, by staff members of a large children's agency which operates foster care programs in Great Britain.

EIGHTY-EIGHTH ANNUAL FORUM OF THE NATIONAL CONFERENCE ON SOCIAL WELFARE, Minneapolis, Minnesota, May 14–19, 1961.

Samplings of papers delivered at the Forum appear in the following volumes:

The Social Welfare Forum, 1961: official proceedings. Columbia University Press, New York. 1961. 325 pp. $5.

Casework Papers, 1961. Family Service Association of America, 44 East 23rd Street, New York 10. 1961. 149 pp. $2.50.

Community Organization, 1961. Columbia University Press, New York. 1961. 212 pp. $4.

New Perspectives on Group Work: theory, organization, and practice. National Association of Social Workers, 95 Madison Ave., New York 16. 1961. 160 pp. $2.50.

READERS' EXCHANGE

GOLD: *A community problem*

In "A Broad View of Maternity Care" [CHILDREN, March–April 1962], Dr. Edwin M. Gold has challenged us to integrate all of our resources in meeting the multifaceted problems of maternal and infant health and to utilize a team approach which embraces all the medical, health, and social disciplines. His sound proposals should be a stimulus and guide for renewed efforts to mitigate the tragic losses associated with childbearing.

The reduction of perinatal and maternal casualties is a much more complicated problem than the mere acquisition of new knowledge concerning the classic art of obstetrics, than knowing when and how to intervene and when it is best to support the patient without active intervention. These casualties form a sensitive index of the social and economic level of a community. Their impact affects the entire community. Responsibility for the formulation of a community health program to provide a continuity of good medical care, which begins as early in life as possible, cannot be relegated exclusively to any single group of medical workers. Moreover, further progress depends upon wider application of what is now known about obstetric and pediatric care; and this involves an expansion of both professional and lay education on a continuing basis.

Maternal and perinatal mortality rates vary significantly in different communities and among population groups within a given community. Thus, it is necessary to broaden the objectives of modern obstetric care to provide a continuum of care for all females prior to and during the reproductive years, with a view toward promoting and maintaining a general health status that is optimal for childbearing. Since pregnancy inefficiency seems to be concentrated in minority segments of the population, it is important to identify the mothers affected by the greater risk of disproportionate wastage problems and to concentrate available resources upon them. A continuing analysis of maternal and perinatal mortality and morbidity at the local level is helpful in disclosing the high priority risk patients in the community who have the greatest need of intensive workup and care.

Broad areas of research must be encouraged in all basic levels of human reproduction and comparative physiology because new knowledge suggests new clinical approaches. However, the problems of maternal and infant health must be solved ultimately through the coordinated activities of multidisciplinary groups who apply this new knowledge on a continuing basis throughout all segments of the population. Dr. Gold's broadly based program, which embraces the institutions involved in social and economic reform as well as the general health field, should be read by all medical workers.

Robert E. L. Nesbilt, Jr., M.D.
Professor and Chairman, Department of Obstetrics and Gynecology, State University of New York Upstate Medical Center, Syracuse

HOW MANY WILL DIE?

How many children will die this year because their parents thought incorrectly that the youngsters could swim? What can we as social workers, pediatricians, nurses, or whatever, do to help prevent such drownings?

A few years ago I assisted a community agency in interviewing parents about further swimming courses for their children. These parents seemed well balanced and interested in family welfare—they loved their little ones. It was to be expected that out of pride most parents would to some extent exaggerate the aquatic abilty of the children, but it was alarming to note the number of parents that thought their children could swim when they actually could not. Here is what one parent said: "It was silly but we just accepted John's statement that he had learned to swim. Then we let him get into deep water on an outing and he almost drowned—he could barely float."

Each spring since these interviews, I try to inquire casually of parents in my caseload about the swimming plans that they have for their children during the warm weather. Most parents have interpreted the question not as an imposition on their rights but as a friendly sign of interest in their families. Four of the parents I asked indicated that their children, for example, could swim, and would be allowed to go along with peers to "the old swimming hole." But when they stopped to consider the matter, they realized that they had never actually seen their children swim; they checked with the swimming coach and were told that the youngster could just about float and were advised to let them use only a supervised pool. Two other parents felt comfortable about their swim plans and let the children "try their luck" in a lake or river with adults present: both parents reported near drownings.

Harry E. Grob, Jr.
Family Service Agency, Quincy, Illinois

A PLEA FOR HELP

I am preparing a detailed annotated bibliography on the "Multiproblem Family." I am planning to include articles, books, theses, mimeographed material, speeches, and projects on the topic. The following countries will be included: Australia, Canada, England, Holland, and the United States.

I would like to ask the help of readers of CHILDREN in my search for relevant material, in the form of reading lists, reports, project outlines, reprints, thesis abstracts, and other items on the multiproblem family for inclusion in the bibliography. I will, of course, pay for any of the material sent me for which a price is given.

This "annotated bibliography" will be published by the University of Toronto Press early in 1963.

Benjamin Schlesinger
Assistant Professor, School of Social Work, University of Toronto

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U.S. GOVERNMENT PRINTING OFFICE: 1962

SOME U.S. GOVERNMENT PUBLICATIONS FOR PROFESSIONAL WORKERS

Publications for which prices are quoted are for sale by the Superintendent of Documents, U.S. Government Printing Office, Washington 25, D.C. Orders should be accompanied by payment. Twenty-five percent discount on quantities of 100 or more.

YOUR CHILD FROM 1 TO 6. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. CB Publication No. 30. 1962. 98 pp. 20 cents.

An entirely new edition of a publication that has been revised and rewritten periodically since it first appeared in 1918 to help parents understand how these children grow and how they can help them develop their potentials. The pamphlet presents a short overview of the preschool years, when a "child changes more than in any other 5 years," and devotes a chapter each to children of 1 to 3 years; 3- and 4-year-olds; 5-year-olds; special problems—such as moving or going to the hospital; keeping the child healthy; when a child is sick; and emergencies.

RESEARCH RELATING TO CHILDREN, Bulletin no. 14. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau, February–September 1961. 1962. 132 pp. $1.

This bulletin, like previous issues, includes reports of research in progress or very recently completed, in such areas as: growth and development; personality and adjustment; the educational process; exceptional children; the child in the family; social, economic, and cultural influences; health services and surveys; and social services and surveys. Only projects reported to the Clearinghouse for Research in Child Life during the designated period are included.

BLIND CHILDREN: degree of vision, mode of reading. John Walker Jones. Department of Health, Education, and Welfare, Office of Education. OE Publication No. 35026. 1961. 38 pp. 25 cents.

This pamphlet presents descriptive and statistical data regarding 14,125 children in day or residential schools who were registered with the American Printing House for the Blind in January 1960, as "legally blind" (having 20/200 vision or less) showing that less than 25 percent are totally blind. The material throws light on educational classification and placement practices in regard to such children and on the degree of application of the modern theory that legally blind children who are not totally blind should make maximum use of their residual vision by reading print instead of braille whenever possible.

COOPERATIVE RESEARCH: types of tests in Project Talent. John T. Dailey and Marion F. Shaycoft. Department of Health, Education, and Welfare, Office of Education. Cooperative Research Monograph No. 9. 1961. 62 pp. 25 cents.

Especially for the benefit of school personnel planning programs of testing for aptitude and achievement, this monograph presents a brief outline of the history, purpose, development, description, factors measured, uses, and interpretation of standardized aptitude and achievement tests, as represented in the Project Talent. This research project is conducted with the cooperation of several Federal agencies at the University of Pittsburgh, with which the authors are associated.

JUVENILE DELINQUENCY REFERENCES. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. 1961. 10 pp. 15 cents.

This annotated list of published material available from the Children's Bureau on juvenile delinquency includes the Facts and Facets Series and publications and article-reprints on community organization and group work; police services; legal and correctional aspects; institutions, detention and aftercare; staff training; and research.

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SEPTEMBER • OCTOBER 1962

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Assistance to Other Cultures

Parents of the Retarded

Foster Care of Delinquents

Informing Parents of Defects

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children ®

VOLUME 9
NUMBER 5
SEPTEMBER–OCTOBER 1962

LEARNING is a serious business for children all over the world, as the concentration of this child suggests; and in the developing countries of Africa it has become almost a passion. How UNICEF is helping such countries to meet the educational expectations of their people is described on page 200 of this issue.

The photo is from the book, "Incredible Africa," recently published by the John Day Co., Inc.

◀ *the authors*

Dr. Derrick B. Jelliffe (left) received his medical training at London University and has graduate diplomas in child health and tropical medicine. He has been on the medical faculties of universities in the West Indies, India, Nigeria, and the United States as well as in Uganda. Dr. F. John Bennett (right), who received his medical and public health training at the South African universities of Cape Town and Witwatersrand, has held public health positions in Cape Town, Worcester, Basutoland, and Natal, South Africa.

Among the various tasks Alice V. Anderson has carried out in her 25 years of social work has been the conducting of orientation group meetings for mentally ill patients at St. Elizabeths Hospital in Washington, D.C.—an experience not unlike her work with groups of parents at the D.C. Clinic for Retarded Children, whose staff she joined 3 years ago. With a master's in social work from Howard University, she has also worked as a child welfare consultant in Korea.

In addition to supervising the program for delinquent girls she describes in her article, Elizabeth V. Hunt has responsibility for her agency's adoption program. Her entire career since she entered the welfare field during the depression of the 1930's has been in public welfare, with the focus, since 1943, on child welfare. With her master's in social work from the University of Minnesota, she has served as clinical field instructor for graduate students from the university's school of social work.

With a particular interest in the physical, mental, and personality development of children, Dr. Arthur H. Parmelee, Jr., heads the division of child development of the University of California Medical Center at Los Angeles, where he is also associate professor of pediatrics. He became a full-time member of the university's department of pediatrics after three years of private practice in the Pacific Palisades.

For more than 20 years before moving to Phoenix in early 1961, Dr. Irene M. Josselyn practiced psychiatry and psychoanalysis in Chicago, where she also was on the staff of the Chicago Institute for Psychoanalysis for 11 years, and served as consultant to a variety of social agencies. At present she carries on a private practice, edits the *Journal of the American Academy of Child Psychiatry*, and serves as consultant to a veterans' hospital.

Helping the developing countries to build up maternal and child health services means finding solutions to . . .

CULTURAL PROBLEMS IN TECHNICAL ASSISTANCE

DERRICK B. JELLIFFE, M.D.
UNICEF Professor of Child Health

F. JOHN BENNETT, M.B.
Senior Lecturer in Preventive Medicine

Makerere University College Medical School, Kampala, Uganda

OF THE NUMEROUS definitions of "culture," we tend to use one which fits our thesis best. In this article we use the word to refer to the whole way of life of a group of people—including the artifacts produced; the adaptation to the environment; the shared mosaic of belief, feeling, and behavior; and the patterns of relationship between individuals.

Many of the cultural problems of giving technical aid in the field of maternal and child health in developing regions arise from the donor's Western-based scientific cultural conditioning rather than from the recipient culture.[1-3] In tropical countries these problems arise in connection with five major aspects of maternal and child health, or as we usually say, MCH work:

1. The evaluation of the country's health problems and the establishment of health statistics.

2. The provision and training of personnel.

3. The organization and operation of maternal and child health services.

4. Nutrition education.

5. Health education.

In most underdeveloped countries there are no accurate vital statistics relating to illness and death among mothers and children. Usually even census figures, showing the proportion of children of different ages in the population, are not available. The maternal and child health worker is thus faced with an imperfect knowledge of his major problems and no baseline from which to gauge progress. Moreover, he lacks one of the most effective weapons for overcoming public and administrative inertia.

One of the commonest difficulties in carrying out a census in newly developing countries lies in the fact that many people do not like to have their children counted. This reluctance is sometimes due to a general mistrust of strangers, sometimes to a suspicion that the process is related to tax registration, and sometimes, as among the Baganda in Africa, that it is tempting providence to draw attention to family size. At Makerere College Health Center in Uganda, it has taken over 2 years to obtain an approximate census of a relatively small area. The process was additionally handicapped by the lack of villages or groupings of dwellings in the area, and by the local custom of sending children to live with relatives, who maintain they are their own.

In many developing regions, as among the Zulus, the maintenance of census figures around a health center is further hampered by the continuous movement of men, women, and children between towns and rural areas. Similar problems are present to an

even greater extent among such nomadic peoples as the Karamojong cattle raisers of Uganda or the Hadza hunters of northern Tanganyika.

Attempts to receive notification of births, deaths, and illnesses may also meet with little success owing to a general fear that the information might be used for ulterior motives, especially taxation, and also because of local concepts of the cause and significance of these events. For example, death of a newborn may be considered a result of a mother's promiscuity, and so a cause of shame which should not be revealed.

Inaccuracies in health statistics may also result from a variety of other cultural concepts and practices. In some communities, births, and in others deaths, are accompanied by much obvious ceremonial, which may lead to overreporting on the part of field observers. In parts of southeast Asia problems arise from the belief that the death of a baby is of little consequence since he had not yet been initiated into his community, and to the superstition that it is inauspicious to reveal the name or sex of a newborn.[4]

Rituals, Taboos, and Disease

Hospital statistics in some underdeveloped areas may be subject to even greater bias because people believe that certain diseases are not amenable to modern scientific medicine, and, therefore, do not present themselves for treatment. For example, among the Zulus, important communicable diseases, such as tuberculosis and syphilis, are thought to be forms of poisoning and bewitchment, best treated by indigenous practitioners. Especially where concepts of causation include the transgression of social taboos are people likely to think that such diseases only occur among themselves and, therefore cannot be understood or treated by the foreign-trained.

Statistical bias can also occur in hospital and clinic practice in relation to certain age groups. Thus, in New Guinea, the incident of neonatal tetanus seemed to be much less than might have been expected. This, however, was not because the disease was not widespread, but because mothers and newborns were kept in ritual postnatal seclusion during which many babies died without ever being seen.[5] Similar situations probably exist elsewhere, as in India where postnatal seclusion is customary.

Yet another factor making precise diagnosis and hence precise statistics hard to achieve in hospital work, particularly in Moslem societies, is the great difficulty in obtaining autopsies, especially on children. Moreover, in most tropical countries where the fear of witchcraft is widespread, the removal of pathological specimens at post mortems is viewed with much suspicion. The use of human tissue, whether nails, hair, or flesh, is a basic maneuver in many magical processes, such as the potent *borfima* (charm) of the Leopard Men of Sierra Leone, an essential ingredient of which is human omental fat.

Much so-called "buried disease" exists among children in the tropics including illnesses that do not reach the attention of the pediatrician, who is apt to be preoccupied with the constant battle against such overwhelming problems as protein-calorie malnutrition and diarrheal disease. Even Western-labeled "behavior problems" may occur, but, as they are not recognized as constituting problems at all in a different cultural nexus, they are not reported. Since bed wetting among Baganda children is a source of pride, as it portends great fertility and potency, a Baganda peasant mother would certainly not consider it as something to mention to the doctor. Nevertheless, it might occur under exactly the same conditions as in European and American children.

In spite of these difficulties, prevalence studies are extremely helpful for the MCH worker in an underdeveloped country, for they not only acquaint him with the relative commonness of disease in the community itself, but also help him learn something of the causative environmental and cultural factors responsible. Surveys of this type, in which students participate as "teaching safaris,"[6] are carried out by the Departments of Child Health and of Preventive Medicine at Makerere Medical School as a continuing series of community studies in child health in east Africa.[7]

Certain maneuvers employed in such field studies may create difficulties because of cultural misinterpretation. The sucking up of blood into a pipette to obtain a specimen may be thought to be blood drinking for magical reasons, an idea that is reinforced if the staff member concerned is a woman wearing red lipstick. Again the weighing of children may be regarded as tempting providence, or the collection of stool specimens feared, lest they be used for bewitchment.

Wherever a high incidence of some particular disease is discovered, whether by survey or by clinic notification, it is, of course, necessary for applying preventive measures logically to determine etiologic "molding forces." These often lie as much in the field of human behavior as in the environment alone. Before attempting the investigation of etiologic factors, the MCH worker must acquire as much knowl-

edge as possible of the local culture pattern. Otherwise he will have little idea even where to begin to seek the complex factors making up the mosaic of causation. Hours spent on reading anthropological literature and on discussions with local people about their lives are, in fact, hours spent on gaining medical insight.

Only after such preliminary exploration can the form, scope, and aims of technical aid in MCH programs best be determined and deployed. In fact, an evaluation of problems and their causes is a most urgent research project for developing countries.

Orientation courses conducted by anthropologists, sociologists, and members of the recipient community could well form part of the training of new foreign recruits to underdeveloped areas.

Provision and Training of Personnel

Foreign personnel often work with many disadvantages which prevent them from being as valuable to a country lacking technical experts as they otherwise might be. In Africa, for example, many foreign workers have personal feelings of not belonging, of being unable to identify themselves with the people for whom they are working, or of disillusionment arising from their discovery of the hugeness of some of the problems the countries face and of the smallness of any immediate contribution that they themselves can make.

One of the greatest problems in technical assistance is the language barrier. Without knowledge of the local language, the MCH worker is always one step removed from his patient. Yet few consultants can spare the time to learn one or more new languages while, at the same time, having to learn so much else about the local situation and to deal with the flood of other problems inherent in their work.

To overcome the handicap of his foreignness, the technical assistant must adjust himself as quickly as possible to the culture and society in which he is working. He must make genuine friends among the local people and must try to cast off the blinders imposed by his own culture. He must rid himself of the "Jehovah complex"—the feeling that he unaided can make immense improvements—and must realize that his greatest contribution will be in the degree to which he stimulates the local population to recognize and solve their own problems, and to which he encourages and teaches local colleagues.

The training of local personnel to carry out maternal and child health work is a top priority of technical aid programs in underdeveloped countries. The tutors are often foreigners or local persons who have been trained overseas. Above all they should not teach out of their foreign culture, but should clothe the scientific bones of their instruction with flesh and muscle of the local culture pattern. Often one still finds locally trained workers repeating the "orange juice and bottle-feeding" information that they have unnecessarily and dangerously been taught.[8]

In most developing areas, there are available little money, few teachers, and very few candidates with suitable basic qualifications for training to the professional level. Auxiliaries, therefore, have to be trained at lower levels to supplement the work of the few professional workers. The relationship between professional and auxiliary must be both supervisory and advisory—the greater the gap in qualifications, the more emphasis being placed on supervision. Many foreign professionals, however, have never worked with auxiliaries, and teamwork suffers as a consequence. Training often has to be radically different than in the teacher's own country and material for teaching, including textbooks, may have to be prepared for the local culture, perhaps even in the vernacular.[9]

The selection and stimulation of local individuals to specialize in pediatrics, once regarded simply as

Student midwives in Kuching, Sarawak, feeding a newborn infant. Bottle feeding is supplanting breast feeding in this community, although families rarely have the kind of refrigeration that protects the baby's formula from bacterial contamination.

procedures of providing scholarships to Britain, the United States of America, or elsewhere, are not so simple when viewed from within the country concerned.[6] Does postgraduate training in a highly advanced country equip a person suitably for tackling problems which may have their origin in a cassava and plantain diet? Is not higher education in Europe and America too bound up in Western culture to fit the MCH worker for practice in a totally different society?

The contribution of modern scientific training to the personnel problems of the tropics would be much greater if attention were paid to variations among cultures and societies.

MCH Services

Antenatal care in many societies consists of the use of medicines to prevent the fetus from being harmed by bewitchment or other noxious influences: and of the observance of certain rituals and taboos.[10] Sometimes these practices may be directly harmful in themselves; more frequently they exert an indirect deleterious effect by preventing the mother from seeking modern antenatal care.

Scientific maternity care, no matter how well distributed, may have little appeal to people if it does not cater to traditional beliefs, such as those regarding importance of the way the umbilical cord is cut or the disposal of the placenta. In some societies the person conducting the delivery has traditional duties in connection with the care of the home or of the mother during her period of ritual seclusion, which a foreign-trained midwife does not fulfill. Scientific midwifery, therefore, in its techniques, its equipment, and its personnel, may be at variance with local customs and traditions, and unless it can make the necesssary adjustments it will be unlikely to be fully utilized.

Some seemingly trivial customs in the immediate postnatal period can have far-reaching consequences. In some societies the tradition of placing cow dung on the baby's umbilical stump is responsible for a high incidence of neonatal tetanus. In others, failure to tie the cord, common among the Baganda, results in hemorrhage and neonatal anemia in the newborn, necessitating emergency transfusion. Understanding of such dangers has to be transmitted through health education to expectant mothers who are going to be delivered at home and through the training courses to the midwives.

In the care of premature babies, special attention has to be paid to keeping up lactation, for failure of the mother to produce breast milk is usually a death sentence for a baby among poor people in tropical regions[11] where hygienic bottle feeding is almost impossible to achieve. Difficulties can arise if the person in charge of a premature unit does not understand the need to encourage mothers to express breast milk until their infants can suckle for themselves.

Infant welfare clinics can rarely limit their clientele to well babies in tropical areas where a procession of sicknesses of one degree or another is the fate of the majority of young children. Failure to understand this is a common Western-based cultural difficulty in MCH assistance, as many workers have tried to make their clinics approximate the streamlined weighing, counseling, and immunizing sessions of North America and Europe.

Tropical hospitals usually have to make arrangements for the admission of a mother with her child. This represents an extremely valuable opportunity for health education and is, of course, imperative for the continued breast feeding of the younger child. But it also leads to a slight change in the nurse's role in the hospital, for the mother does much of the actual nursing of the child such as feeding and bathing, while the nurse mostly supervises and performs more technical tasks such as giving injections.

Many predominantly rural countries have developed a system of health centers, each with a team of medical, nursing, health education, and sanitation workers, combining their efforts to improve the health of the surrounding community. Knowledge of the material culture (such as housing, methods of disposal of excreta, water supplies, and available foods), the beliefs and values of the people, and their family structure is vital for the success of this teamwork as it is in all aspects of MCH work.

The provision of medical services sometimes has to be adapted drastically to the way of life of the community. For example, to reach the pastoral Masai in Kenya mobile health centers have been established which sometimes have to concentrate their activities around communal waterholes.

In no other aspect of child health is intimate knowledge of the local culture so absolutely vital for MCH workers as in nutrition; for the nutrition of a community depends not only on the production of foodstuffs, but also on the methods of food storage and food preparation and on the attitudes of the people to foods.

In some tropical regions, as in Buganda in east Africa, sufficient nutrients are available to prevent malnutrition, but despite this, protein-calorie malnu-

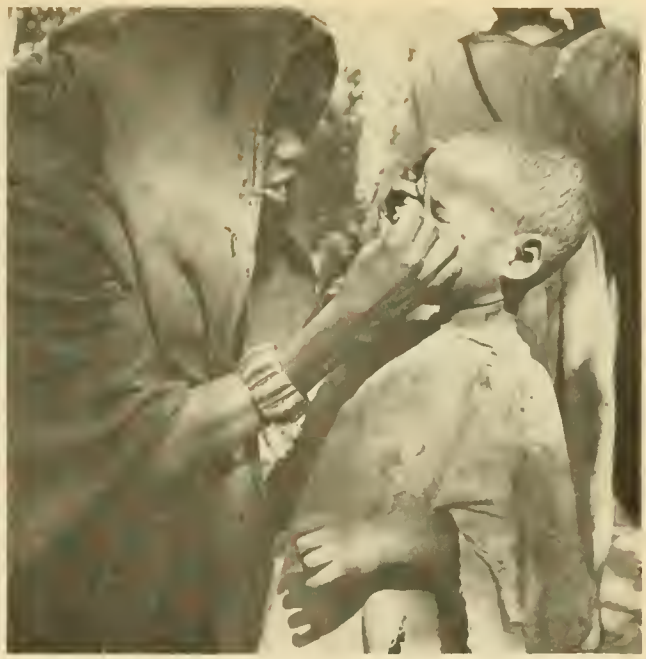
trition of early childhood is common because people do not make full use of the nutritious foods available.[12, 13] This failure to use what is available is often due to the idea that one type of food only is really food, and that other items are of no consequence. These cultural "superfoods" include steamed plantain (*matoke*) in Buganda, rice in much of southeast Asia, and maize in Central America. Also in some places certain types of food are prohibited to the whole community sometimes for elaborate cultural reasons, but sometimes merely because the particular item is not regarded as food.

Man everywhere, even under adverse conditions, eats only part of the actually edible material available. Even the nutritionally hard-pressed Hadza hunters of Tanganyika will not eat the blood of animals and meticulously discard the apex of the hearts of animals they have shot. Moreover, in almost every country there are prevalent concepts regarding the suitability of certain foods for certain people, especially children. Sometimes these ideas are nutritionally harmful, as in Malaya where fish, the main source of animal protein, is forbidden to children until they are 2 years old as it is believed that, if eaten by a younger child he will get worms.[14] Similarly, in parts of India the age-old *tridosha* (humoral) concept of body physiology means that a "hot" food, such as milk, must not be given to a person suffering from a "hot" illness such as diarrhea, even during recovery. This can have nutritionally ill consequences in a previously subnourished infant.

In many places the ideas that young children need specially prepared foods and three or four meals a day are practically unheard of; people do not make the Westerner's customary association between growth and food, between the qualities of different foods, and between malnutrition and a lack of certain foods. Thus kwashiorkor, although widespread in many tropical regions, is rarely equated with nutrition. Under these circumstances nutrition education is especially difficult, as the people are not motivated to make innovations in their food habits except in times of famine.

There is a widespread belief that eating well during pregnancy is undesirable since this might result in an overlarge fetus with consequent difficulty in labor. In Burma a customary maternal diet of small amounts of boiled polished rice means that the neonate has little stored thiamine. This contributes to infantile beriberi.[15]

However, in some tropical communities the pregnant woman is given a more nutritious diet than

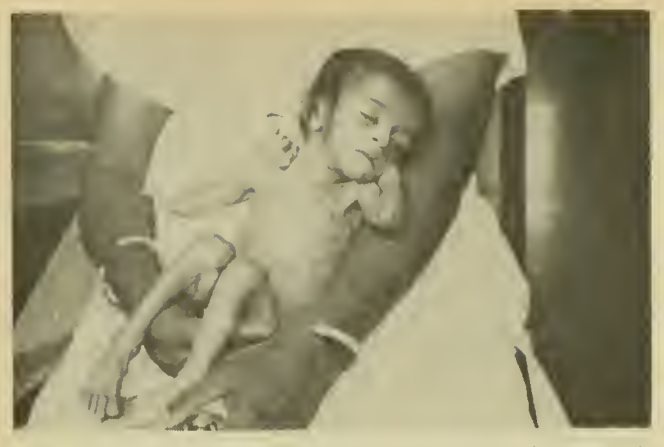


This Berber mother in Morocco only recently learned that she could not cure her child's infected eyes with drops from the gall of a freshly killed vulture. Now she uses an antibiotic ointment supplied by UNICEF in its campaign against trachoma.

usual. Thus among the Basuto in South Africa, pregnant women eat porridge made of sorghum, which is more nutritious than the usual maize. When such a beneficial custom exists, it should be encouraged and incorporated into nutrition education.

Because a people's use of foods is usually so bound up with their whole way of life, dietary custom is one of the most difficult areas of behavior in which to achieve any fundamental change. Small modifications based on indigenous practice are the most likely to be accepted. In Buganda mothers are being encouraged to use the traditional plantain leaf packets for preparing special high-protein meals for babies.[16]

For the majority of infants in tropical countries, breast milk is the *only* food given until the child develops one or two teeth. Thereafter, throughout infancy, breast feeding is continued, providing a small but significant protein supplement as the more digestible and nutritious portions of the available diet—protein foods both of animal and vegetable origin—are gradually added. However, among some tropical people such as the Bemba of Northern Rhodesia, breast milk is not regarded as food and other items are added early to the baby's diet, often leading to gastroenteritis.



This bottle-fed child in Trinidad is suffering from nutritional marasmus caused by infectious diarrhea and starvation.

Milk powder issued freely in child health clinics tends to encourage mothers to abandon breast feeding in favor of bottle feeding, unless the firm policy is adopted of mixing the powder directly with local foods.

The practice of direct distribution of the powder and the high-powered advertisement by milk-powder firms are potent factors in the falling off in breast feeding occurring at the present day in tropical regions. Among the unfortunate results is an increased incidence of gastroenteritis caused by pollution of the feeding through unsanitary methods of preparation and of nutritional marasmus caused by overdilution of the formula.[17]

The causative factors behind protein-calorie malnutrition—the major nutritional problem of underdeveloped areas—are rarely entirely nutritional. In Buganda, for example, the high incidence of kwashiorkor is undoubtedly correlated with the increasing tendency to stop breast feeding at even earlier ages and the reliance on a diet of steamed plantain. At the time of weaning, children are often sent away to relatives, especially a grandparent, and thus are subjected to emotional as well as nutritional deprivation.[18] One reason for this geographical separation at weaning is the belief that one form of kwashiorkor (*obwosi*) is due to the heat from a mother's pregnant uterus.

This practice of sending children away often delays treatment of the sick child as an older relative is more likely to hold the local concept of etiology and to rely on indigenous methods of treatment. Moreover, if modern therapy is not rapidly and obviously effective, the child is often removed from the hospital for herbal treatment at home. In Uganda a large proportion of milk powder is wasted because people are not prepared to persist with modern methods of treatment that take several weeks to produce a cure.

In planning health education, not only do the beliefs, attitudes, and behavior underlying the disease pattern have to be understood in order to formulate adequate educational objectives, but the structure of the society has to be understood also to enable the best use to be made of situations and personnel. Methods and media of communication have to fit in with what people know and can understand and accept.

In Buganda one of the major diseases of children is hookworm anemia, which lowers hemoglobin levels to a point necessitating emergency blood transfusions. Investigation carried out recently showed that while many adults used adequate pit latrines, children were sent to small, very shallow pits, or perhaps to just a defecating area in the plantain grove. The reasons usually given for this practice were that children if permitted to use the adults' latrine would soil it, or fall in, or would see their parents defecating; but another reason seemed to be a general feeling that the feces of younger and older generations should not mix.

Buganda parents of children with hookworm did not notice the pallor of their children's mucous membranes, nor did they attribute the disease to worms. The only intestinal helminths the parents did recognize were roundworms (thought to be due to the mother's unfaithfulness and, therefore, not usually reported), tapeworms, and pinworms. They were aware of a skin disease suffered after working in the fields, which was probably "the ground itch" due to the penetration of the skin by the hookworm larvae, but they tended to confuse the edema of severe hookworm anemia with the similar picture of kwashiorkor for which they had indigenous ideas of causation and treatment. Most peasant families could not afford to buy shoes for their children, who in any case probably gave the larvae plenty or opportunity to penetrate through the back, buttocks, and thighs.

When this information was gathered, pediatricians and other health workers were immediately struck by the unsuitability of their program of health education. They had been placing emphasis on the details of the offending organism's life cycle, using diagrams of the course of the larvae through the lungs and blood vessels—none of which could be understood by the local people. The health educa-

tion program was, therefore, redrafted to put emphasis on the transmission of the organism from feces on the ground to the human body through the skin, thus producing "ground itch" and the eventual result of loss of blood from the bowel. As visual aids, actual worms expelled from a patient were exhibited, together with before-and-after color photographs of the patient's mucous membranes. The chief emphasis was laid on ways of recognizing anemia and on the necessity of building latrines for children with the hole surrounded by an impervious material. All the old visual aids with dragon-size hookworms, anatomical line drawings, and emphasis on shoes and adult latrines were discarded.

With rapid culture changes and urbanization in most developing areas, new problems of health education have arisen, and will do so increasingly in the future. We have already noted one of the most serious, the abandonment of breast feeding. The difficulty in propagandizing against bottle feeding is that many members of the elite do not breast-feed their children. Efforts to persuade the poor to feed through the breast rather than bottles are apt to be interpreted as efforts to withhold something from the masses. Moreover, campaigns to encourage breast feeding are likely to make mothers self-conscious about it and so interfere with the complex psychological reflexes which seem to require that the whole process be taken for granted if it is to function naturally.

In Conclusion

Thus we see that a society's traditional food habits, child-rearing practices, and habits of personal hygiene along with other cultural factors shape the disease patterns of a community. The structure of the community, the functioning of the family and its attitudes toward innovation, the beliefs and attitudes of the people in regard to childbearing, disease causation, and food must all be taken into account in determining the work, the personnel, and the emphases of child health services. There must also be an awareness that the changes induced by the agents of modern scientific medicine are themselves not always beneficial, so that potential deleterious effects can be anticipated, and, if possible, prevented in advance rather than regretted later.

Cultural inexperience is expensive and wasteful. One million pounds of milk powder or a corps of experts may make no impression whatsoever on a problem, if the local culture pattern is ignored.

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Some day we shall be ashamed not to know how our neighbor lives, and when we truly know how he lives and why his children suffer, that kind of living and that kind of suffering will cease.

Julia C. Lathrop, first chief of the Children's Bureau, to the Illinois Conference of Charities and Corrections, Alton, October 22, 1916.

ORIENTATING PARENTS TO A CLINIC FOR THE RETARDED

ALICE V. ANDERSON

Social Worker, District of Columbia Clinic for Retarded Children, District of Columbia Department of Public Health

IN THE OPERATION of a clinic for retarded children, the following questions are repeatedly raised:

- How can the waiting list be cut down?
- How can the interest of parents be maintained pending the beginning of the study?
- How can parents be kept from breaking clinic appointments?
- How can parents be best informed about the work of the clinic?

Confronted with these provocative questions, the staff of our clinic set up a system of group orientation meetings in March 1960 for parents at intake as a method for improving the service of the clinic. The problems presented by the long waiting list and failure of parents to understand the clinic's services are now handled more effectively. Broken appointments in a multidisciplinary clinic involving the team approach especially had long been a matter of grave concern, since a broken appointment affects several staff members simultaneously, thus wasting the service of the clinic and allowing fewer children to be served.

The meetings, which are held in the evening, were organized and conducted by the chief social worker for parents of children on the waiting list. These are parents who so far have not been interviewed at the clinic. They have either telephoned the clinic to inquire about the possibilities of service for their child or have come to the clinic's attention through a telephone call from a doctor or another professional person. In either case the clinic has received little information about them other than identifying data. During the meeting, each parent is given a schedule of individual appointments with the social worker, clinical psychologist, physician, child development specialist, and speech and hearing specialist.

Since March 1960, the meetings have been held at regular intervals and are now attended by the pediatrician-director who acts as a medical resource consultant to the group. The parents are seen in groups averaging about 10 couples each. The individual appointments for each child and parent are spread over a 6-week period, the first parent coming to the clinic with her child a week after the meeting for the beginning of the study.

The group meetings provide the staff with a chance to find out which parents are still interested in the clinic service and to obtain from them signed forms permitting the staff to send for pertinent medical and social information in advance of their individual interviews. The meetings' most important advantages for the staff, however, lie in the opportunity they afford for observing the parents and gaining insight into each couples' attitudes toward their child, toward each other, and toward other parents with a problem similar to their own.

The rationale of this approach is to meet the parent's need for service at the time of the request. The parent who has contacted the clinic has already overcome one hurdle by beginning to accept the fact that his child may be retarded. Therefore, it is vital to provide service to him at a time when he is still searching for help for his child, before he has had much of an opportunity to become resigned to the child's problem.

Parents usually find some therapeutic relief in learning about the detailed diagnostic procedure the clinic has to offer and in being assured that their child will be seen and assessed by a team of specialists in work with children. The clinic's structure begins to have some meaning for them as they have an opportunity to see and inspect the different examining, testing, and play rooms where the study of the child will take place. Often they express relief at learning that the study is not to be conducted in a hospital atmosphere and that the children will not have to stay overnight.

Nervous tension is often aggravated in a family by the presence of a retarded child. In these discussion groups, tensions are often relieved when parents learn that mental retardation is not necessarily inherited. Some parents also find relief in learning that in comparison with others their child is not so badly handicapped. Parents are also often relieved to learn that their child can acquire self-help skills even though this can be accomplished only through a slow, tedious, training procedure, requiring repetition, relaxation, and routine.[1]

We hear much about parents who shop around from one clinic to another. This is not necessarily as unwise as many persons assume. Since there is considerable variation in medical practice, a parent may want confirmation of a diagnosis of mental retardation just as he might of any other medical diagnosis. Thus our clinic serves parents who may be known to other diagnostic clinics as well as those who are making their first clinic appointment. They are also widely different in educational and economic background, although families from the low-income groups predominate.

In order to help parents sense quickly what they have in common despite their wide differences in background, the group leader always points out that each has come to the meeting because of a deep concern about his handicapped child and that it is important for them not to blame themselves for the handicap. This does not mean that the parents are regarded as a homogeneous group or that they all feel the same way about their retarded child. However, at the time of the meeting they are all expressing their concern as parents of handicapped children. Recognizing this fact creates a sympathetic feeling toward one another and creates interaction among them. Mutuality of interest is more important to the members of such a group than are differences in their socio-economic, cultural, or educational background.

The social worker, through a permissive attitude, attempts to provide a "safe" climate for frank discussion among the parents. In the first part of the meeting she describes the clinic's services and what is expected of the parents. She also introduces some mental health concepts, pointing out that the clinic staff is as much concerned about the social adjustment of the child as with his physical condition. She also presents the concept of mental retardation as a symptom of biopsychosocial malfunction.

She encourages the parents to think of their child first and the handicap second, so that it becomes more than a difference in words when they say "my child who is retarded," rather than "my retarded child." Another point she stresses is that the mentally retarded child has the same desire to belong and be accepted by others as the nonretarded, and that in general his emotional needs for recognition, companionship, and a sense of usefulness are the same as those of the normal child.

Orientation Techniques

Many parents of retarded children deny the fact that their child is different from normal children before they finally accept reality. In these group meetings the social worker does not try to convince a parent that his child is below average for she realizes that while the discussion may be helpful in modifying the parent's attitudes, time will be the most important factor in this regard.

In describing the clinic, the social worker points out that it has been set up as part of the city's health program to provide complete diagnostic study and evaluation for any child under 18 who is a resident of the District of Columbia, and in whom there is a question of mental retardation. The parents are given a description of what goes into the diagnostic study and followup services, and of the work of the various staff members who participate: a pediatrician-director, two social workers, a psychologist, a child development worker, a nursing consultant, and a psychiatric consultant who have at their disposal various other consultants from the health department's staff including specialists in speech and hearing, neurology, electroencephalography, physical and occupational therapy, orthopedics, ophthalmology, and cardiology.

The social worker compares the clinic team approach to a family, telling how each member contributes his particular skill in order to help the other team members to do a better job as well as to help the retarded child. She also stresses the informality

and friendliness of the team members in order to help the anxious, hard-to-reach parents to become more relaxed so that they can become active participants in the study.

Focus on the Child

The second part of the meeting can be described as a group-intake interview through parent discussion. Social workers who have had responsibility over the years for individual intake interviews generally acquire considerable skill in quickly assessing the client's problem. This skill can be transferred to a certain extent to a group-intake setting. Of course, when a group is present the social worker cannot do as much interpretation of individual problems nor pick up immediately on some of the emotionally charged clues which emerge from the discussion. However, these clues often point the way to the focus of the subsequent individual interview.

What makes the intake interview so challenging, whether in an individual or a group setting, is that at this time, as the client presents his problems, the social worker is in a position to receive the full impact of his personality and his reactions to his problems. Later as the relationship continues and more detail complicates the picture, it is often more difficult for the worker to identify the trends which are significant for the assessment of the handicapped child in relation to his family.

As the parents describe their child's behavior, it often illustrates the child's social maladjustment. Problems in behavior such as short attention span, hyperactivity, temper tantrums, and a high degree of distractibility are described rather than examples of slow intellectual performance. It becomes evident that the children referred to our clinic are like the children at the Edenwald School of the Jewish Child Care Association of New York—"a group with retardation, emotional disturbance, and organicity all mixed up in a complicated dynamic pattern." [2]

When the parents are stimulated to think of mental retardation as a cause of their child's social dysfunction, impairing his ability to adapt, their overemphasis on the possibility of a physical basis to the child's difficulties tends to diminish. For example, the chief complaint of most parents is that their child is not talking, even though he may be several years old. Often parents assume that the child has some defect in his speech mechanism which treatment would alleviate. The social worker tries to help these parents understand that slowness of speech is often one of the characteristics of retardation and that a child usually understands more than he can communicate.

Although parents listen with interest and often ask questions in the part of the meeting devoted to an explanation of the clinic's services, their participation intensifies considerably when the focus shifts to their problems with their child. The social worker refers to this second half of the session as "their" part of the meeting for it is their opportunity to introduce themselves, to tell about their child, his age, his characteristics, and his relations with his siblings, and to state what they want and expect from the diagnostic study.

To get the discussion going, the leader invites the parents to volunteer to talk or to take turns in the order of their seating arrangement, as they wish.

At this point, the parents' interest turns quickly from the group leader to each other, as each parent describes the condition and individual characteristics of his child. The parents generally relate to each other quickly, gaining mutual support and sympathy. Rarely has a parent decided at the meeting that he does not want his child to go through the clinic study, although a few have decided afterward that they would wait a while before having the study made.

Mutual Support

The following example illustrates the way the parents find support in each other. A mother of a little Mongoloid baby had brought in a picture of her child for the clinic personnel to examine. This woman had a great need to deny that her child looked like a Mongoloid. As the discussion progressed, she passed the picture around to the other parents and a number of the parents reacted to it immediately. While some of the parents agreed with the mother that the baby did not look like a Mongoloid and others thought they saw some Mongoloid characteristics, the whole discussion seemed to develop a bond of sympathy and understanding in the group.

Often the group interaction has a more therapeutic effect than the explanations of the group discussion leader. This was true with Mrs. O, who described her 6-year-old daughter in somewhat critical terms by saying: "Mary knows what to do but she won't do it. She will repeat what I tell her to do but will go ahead with her play and ignore what I have said. Punishing doesn't seem to help. When she is asked why, she replies, 'I don't know'."

Obviously feeling irritated and frustrated at Mary's behavior, Mrs. O added, "I want this study

A group of parents who have applied for diagnostic and evaluation services for their children in an orientation session at the District of Columbia Clinic for Retarded Children.

to show me how I can make her do what I tell her to."

Very quickly a father spoke up, saying, "It's pretty hard to make anybody do anything for very long. Maybe it would be better to have someone tell you what might be the reason for Mary's acting up." Mrs. O nodded at this and the discussion continued.

Sometimes the social worker gets clues to be followed through later. A mother described her slow child as being the smartest one in the family about getting her own way. She said her child could run circles around anyone by coaxing, demanding, or making a fuss. Some other parents agreed that they had the same trouble. The social worker made a mental note that these parents needed help in modifying their children's manipulative behavior.

The parents' feelings of guilt do not come out in a group as often as might be anticipated. However, one very articulate, uninhibited father suddenly blurted out:

"Say, I have a sister in a mental hospital; do you suppose that's why my little girl is slow in developing? Would it be my fault since it's on my side of the family?"

Before there was time for the social worker to answer, another parent said: "It is like the lady said earlier: it's not to your credit if your child is bright and it's not your fault if your child is slow."

There have been times in the meetings when mothers have wept as they described their retarded child, but when this has occurred the group has accepted it calmly. One mother who was telling how difficult it is for a woman to handle a handicapped child alone said in a shaky voice: "My husband left me and now my little girl frequently runs away because she wants to find her daddy." The group was very silent as she struggled for self-control.

Another distraught and somewhat hostile mother of a retarded and emotionally disturbed 10-year-old boy said bluntly: "I want my child sterilized because I don't ever want to be responsible for rearing any of his children." The other parents looked stunned at first, and then began talking of their own fears of what the future would hold in the way of social relationships for their handicapped children. The social worker pointed out that many parents worried about this and that society does not provide a pat answer to the problem. She stressed the fact that each child is entitled to a thorough individual diagnostic study before any recommendation is made for his treatment.

Individual tape recordings of 12 of the parent group-orientation meetings have been made with permission of the parents. (They are available upon request to the clinic.) Demonstrating vividly the dynamic interaction which occurs as the parents discuss their children, they reflect both agreement and disagreement about suggestions made by the social worker as well as by the parents themselves, and show how the social worker uses opportunities to comment, interpret, or recommend a "let's wait and see attitude."

Patterns and Values

Over the months we have been able to detect certain patterns in these meetings.

We find that a group of from 8 to 10 couples usually promotes more interaction among the parents than a larger or smaller group.

We find that fathers often take the initiative in describing in detail their child's problems. And, contrary to our expectations, we have often found that fathers are readier to accept a diagnosis of retardation than some mothers. For example, fathers sometimes attend the meeting alone, their wives having stayed home as babysitters, and when this happens such statements as the following are not unusual: "I see this child as very different from other children in the family, but I wouldn't dare say this if my wife were here because she would hit the ceiling."

We find that parents want the support they get from other parents. Often at the end of the meet-

ing parents ask about the possibility of having further opportunities to talk together about their common problems. These parents usually become the nucleus of further parent discussion groups to which parents are invited after the diagnostic study has been completed, the evaluation conference held, and the interpretation given.

The feeling of mutual support engendered in self-led parent groups, such as those sponsored by local parents' organizations, is partly the reason why such groups have grown so in strength and numbers during the past 10 years. However, we have found that some additional advantages are provided when meetings are led by a professional staff person as part of the total diagnostic and treatment procedure of a clinic. This makes it possible for the meetings to—

- Be "treatment-oriented" instead of solely supportive and informative.
- Help parents consider their child's accomplishments and strengths as well as his limitations.
- Help parents, when necessary, to keep from revealing themselves too openly. (When a parent begins an emotional "confession" or starts bringing family skeletons out of the closet, the leader can intervene with a comment which universalizes what has been said or otherwise puts it into an impersonal framework.)
- Make it possible for every parent present to participate in the discussion. (The leader can, when necessary, tactfully terminate the discussion of a dominating member of the group and encourage a less articulate one to express himself.)
- Provide for intervention when the discussion gets blocked on an emotional level that only feeds the members' self-pity.
- Help parents become better informed of community resources which have programs for retarded children.

Although each meeting does not result in all of these advantages, some are always achieved.

The group orientation procedure also saves considerable staff time during the diagnostic study by reducing the parents' need to ask questions at this time. We find especially that parents who have met and talked with other parents who have similar problems do not so frequently ask, "Why did this happen to my child?"

The group-intake procedure also gives the staff opportunity to observe how husbands and wives react to one another, to other parents in the group, and to the social workers, thus gaining some indication of the quality of a couple's marital relations and of their other interpersonal and community relations. It also gives the staff an opportunity to learn about the parents' attitudes toward their child.

Since the clinic recommends but does not require both parents to be present for the diagnostic study appointments, the parent group-orientation meeting often provides the staff with the only opportunity to see the father. This is true even though a visit by the social worker to the home is regularly included as part of each child's diagnostic study.

By providing a means of seeing parents more quickly, the group-orientation procedure avoids anxiety-producing delays not only for the parents but also for the staff. We find that staff morale has improved now that appointments with parents and children can be scheduled well ahead, thus permitting orderly planning and acceleration of clinic work.

However, although the parent group meetings at intake have an educational and an orientation focus, their chief goal is to increase the parents' understanding of their child's problem. Unless the family is helped, factors contributing to the child's problem remain unchanged. When parents are helped through group discussion or individual casework treatment, or both, much can be done to relieve the effect of retardation and help the child to develop to his full potential.

As the parents listen to each other talk about their children, they often gain new ways of looking at their own problems, feel less isolated, and gain emotional support. Treatment actually begins at the parent group-orientation meetings.

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[2] Scher, Bernhard: Help to parents: an integral part of service to the retarded: repetition, relaxation, and routine. National Association for Retarded Children, New York. 1954.

[2] Scher, Bernhard: Help to parents: an integral part of service to the retarded child. *American Journal of Mental Deficiency*, July 1955.

People who are hungry and physically uncomfortable are difficult to reach with rehabilitative efforts.

Norman V. Lourie, deputy secretary, Pennsylvania Department of Public Welfare, to the 1961 conference of the American Public Welfare Association.

FOSTER CARE FOR DELINQUENT GIRLS

ELIZABETH V. HUNT
Supervisor, Department of Services to Children, County Welfare Department of the City of St. Paul and County of Ramsey, St. Paul, Minn.

JUDY, AGE 14, sat glumly before the judge of the juvenile court waiting for his decision. This was not the first time she had been in this chair. In fact, it was the fourth. Her offenses always were unauthorized absences from school or home, or both, once involving a ride in a stolen car, and once—this time—drinking. Each time the judge had placed Judy on probation and returned her to her family. This had not worked. What would he do now?

In working with Judy and her family, the probation officer had found that there were repeated difficulties between this young teenager and her parents, and strong feelings of rivalry between her and a younger sister. The parents had made only inconsistent and ineffective attempts to control her.

The judge again placed Judy on probation, but this time he did not return her to her parents. She was placed under the custody of the county welfare department for a year. Anticipating this order, the probation office had previously made a referral to the county worker who had talked with Judy and her parents. They were somewhat resistant but relieved that she was not going to the training school.

Six years ago Judy might have been sent to the small Ramsey County Home School for Girls, probably for a period of 6 months. The school had a combined function of detention and of ongoing care for girls who, it appeared, should not return to their own homes. The stay was short, often 3 to 6 months, but there many girls gained a different perspective.

Assisting the author in the development of the material for this article were Jane M. Grubb and Sara P. Hill, former caseworkers with the Ramsey County Welfare Department, and Beatrice Bernhagen, director of the department's welfare services to children.

In October 1957 when a detention home for girls and boys was opened, the girls' home school was closed. Its role of providing ongoing care for delinquent girls who could not be at home was superseded by a special foster family care program in the county welfare department. There, of course, continued to be a State training school for girls, known as the State Home School for Girls to provide the group care that some girls need. However, with improved community services, it was anticipated that most delinquent girls could be helped locally.

The specialized program for foster placement of delinquent girls began on January 1, 1958, with one social worker and a supervisor who also had other responsibilities. Because the caseload was expected to build up slowly, it was decided that the social worker who was to deal with the girls would also recruit and license foster homes for the program.

The scope of the program, as it has developed, includes work with the girls and their families, recruiting, licensing and sustaining the foster homes, and community interpretation. Experience has shown that for the worker to maintain a good quality of service in performing these functions, the caseload must be held to a maximum of 15 girls. Even this number allows less time than desirable for work with parents and still less for recruiting homes and making other community contacts. Because almost all of the girls in the program have been placed on probation for a year or longer as a result of a casework assessment of their behavior and needs, the number under care in the specialized program at any one time has become much larger than the former population at the girls' home school. A second worker was added to the program in August 1960.

The girls are referred to the Ramsey County Welfare Department by the probation office following a decision there to recommend to the court the girl's removal from her own home. Criteria for referral derive from consideration of whether the girl would formerly have been sent to the county girls' home school. Use of the county school had been based on a judgment that the girl needed a controlled setting but seemed able to use some freedom, such as going out into the community to attend school. The State training school is used for girls who are, like the others, beyond the control of their parents, who are unable to handle any degree of freedom, and whose associates and general behavior constitute a serious community problem.

The Girls

In the first 3½ years of the specialized foster care program, 66 of the 200 girls who appeared in juvenile court during the period were placed in foster homes. Of the rest, the majority remained in their own homes under supervision of the probation office, some were sent to the State school, and others were already in foster family care under the welfare department's regular boarding care program.

The length of stay in the specialized foster placement varied from 2 days to 25 months, the average being about 6½ months. Ten girls who could not adjust to the foster homes stayed only a few days or weeks. Of those who remained in their own homes, six later went to the State school, and one went to a treatment center and from there to the State school.

The girls who stayed longest in the foster care program were seriously disturbed but seemed to be making small gains under casework treatment. A few girls whose own homes had nothing to offer them have been committed to State guardianship and remain in foster family placement under supervision of another unit of the agency.

Early in the specialized program, most of the girls under its care were kept in placement until shortly before dismissal from probation, in an effort to give them opportunity to gain as much as possible from the experience of living with a normal, healthy family. However, subsequent experience has suggested that it is wiser to return the girls before the end of the probation period to the homes which contributed to their problems and to the schools and communities where they have a poor reputation, and to help them integrate the gains they have made.

Ages of the girls when they entered the program have ranged from 10 to 17, with a cluster around 14 and 15. There have been 59 Caucasian girls, including 2 Mexicans; 6 Indians; and 1 Negro. There have been 29 Catholic girls, 27 Lutheran, and 10 other Protestants. However, these religious affiliations were often tenuous.

The girls have had one to six appearances in court prior to referral and many also have had unofficial police records with no referral to court. Many come from families that have been known to social agencies for years. The average number of agencies which have had contact with the family is 6, the range being from 2 to 16.

The most frequent offense resulting in the girl's referral is "incorrigibility." Other common offenses are running away, sexual immorality, truancy, and drinking. There is some stealing as well as shoplifting, curfew violations, purse snatching, arson, malicious destruction, fighting, auto theft, and assault. The majority of the girls, even the very young ones, have had sexual experiences.

These are girls who act out their problems. They have in most instances shown a marked lack of respect for authority, including the court. They have been subjected to repeated admonitions and warnings from probation officers and court, sometimes without the consistence of follow-through in the establishment of controls. They react with surprise and even hostility when told that they are to be placed in foster care. Often at this point they are being held in the detention home, and their feeling of being punished carries over into their concept of the proposed foster home plan.

Psychological testing done at the detention home shows considerable variance among the girls. Some present the personality structure of many delinquents—impulsivity, immaturity, and rebelliousness—but others do not. From the standpoint of personality structure, these girls differ from one another to a marked degree, but they resemble one another in overt behavior, a common element being infractions of the law. The fact that the most frequent offenses among these girls are more harmful to themselves than to society has undoubtedly entered into the success of placements.

Once the referral has been received, the welfare department caseworker immediately talks with the girl and with her parents. These initial interviews are devoted largely to an interpretation of agency function and procedures, but necessarily include as well the offering of warmth and acceptance, the patient listening to hostility and defensiveness, and a consistent presentation of reality factors. The case-

worker estimates the suitability of foster placement for the girl and prepares a report for the court.

Because the agency has agreed to accept girls who would formerly have gone to the girl's home school on the determination of the probation office, the policy is to attempt to make a placement of every girl referred, insofar as possible, even though the prognosis for successful placement may seem poor, as occasionally it does. Even some girls who opposed placement and threatened to run away have been accepted and placed successfully. In a few instances, however, the agency has recommended against placement of girls who seemed so well established in delinquency as to need other kinds of help, or who refused to cooperate in any way. Some girls referred from the probation office have not been placed in foster care because of the judge's decision to return them to their own homes, keeping them under the supervision of the probation department.

The Foster Homes

Following the court's order for placement, the agency's task of selecting a foster home begins. This requires the caseworker to acquire more knowledge and understanding of the girl and her needs. The actual selection of the foster family for the girl is, however, only a small part of the placement process. The girl, her parents, and the foster parents are all drawn into active participation in an effort to achieve a mutual acceptance between the girl and her foster parents before the girl goes to her new home. The girl and her foster parents are introduced to each other before the placement, usually at the detention home. This tends to reassure the girl that her foster parents know the worst about her and still accept her. The process is complicated, however, by the fact that the detention facilities are often so crowded that there is pressure for the girl's early removal.

Early in the program the staff had some anxiety about whether adequate foster parents could be found to care for girls referred from the court. Many such foster parents have been found, however, through the insertion of ads in the daily paper requesting persons interested in boarding adolescent girls to call the agency. The ads make no mention of delinquency, but during the home studies the caseworkers talk about the special needs of girls who have been unable to live up to society's expectations of behavior. Applicants who have reservations about working with a child who acts out his aggressions are transferred to the agency's regular boarding home department. However, the majority of applicants who have indicated an interest in caring for an adolescent girl are willing, sometimes even enthusiastically so, to take one of these girls into their home. When there is not a licensed home within the specialized program to meet the particular needs of a girl, the help of the agency's home finders from its regular boarding home program is requested. As these workers have become more accustomed to the idea of placing a delinquent child, and have seen it work, they have become increasingly helpful.

Most of the foster parents in the specialized program have been young couples in their late twenties and early thirties with small children of their own. Older couples have occasionally participated, but it has been found that the girls tend to accept young couples more readily and that the younger foster parents are more likely to have a greater fund of patience, resiliency, flexibility, and determination to succeed. Moreover, having the satisfactions of their own families, the younger couples do not demand too much from the girls and are not afraid to risk failure. The girls on their part seem to enjoy children in the home, many having assisted their mothers with their own brothers and sisters. Moreover, helping with the care of the home and the children seems to have a therapeutic effect.

Most of the foster parents have only moderate incomes and modest homes. In some homes the girl can have a bedroom for herself, but in others the girl must share one with a younger child.

No foster parents have requested special board rates on the basis of the girl's record of delinquency alone. Usually they are paid at the same rate as in the agency's regular boarding home program. This is predicated on cost of care, but in the case of such problems as bed wetting, special rates are allowed.

Originally the staff hoped that as time went on a number of foster families would be able and willing to take a second child. However, while in a few instances a second girl has been placed with a foster family after the first has become firmly established, this has not happened to any appreciable extent.

The Girl at Placement

As she comes into the foster home, the girl is frequently attractive but tends to look older than her age. Usually she is physically mature and has a surface sophistication. Her hair is likely to be dyed, her hair style and makeup overdone, and her clothes too tight. Usually she smokes, and has an extensive vocabulary of socially unacceptable language.

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Some of the girls are openly hostile and defiant on first entering their foster homes, but most of them seem only frightened and wanting desperately to be liked and accepted. Most of them have probably suffered early physical and emotional deprivations; but whether this is so is not always known for, except for perusal of old agency records, the caseworkers make no effort to obtain full social histories. The histories of the girls' immediate pasts reveal, in many cases, openly rejecting parents; in others, parents who love their daughter but who because of personal inadequacies have been unable to meet her needs. In nearly every case, the girl has suffered from lack of care and training.

Typically, the girl entering placement has faulty relationships not only with her parents, but also with peers and with other adults. Her identifications, if any, are with other delinquents. Generally, she has a poor school record although she is of normal intelligence. Her life so far has been singularly lacking in achievements and satisfactions, and she has a very poor self-concept. She manipulates those about her because she cannot trust or accept them. She has a pattern of running from an unsatisfactory situation to something she wants and cannot identify. Operating on the pleasure principle because she feels that no one cares about her, she has little tolerance for frustration of her driving desires.

Within this general picture there are marked differences among the girls. The extent of personality damage may be minor or severe. Some girls respond quickly and easily to the help offered them, while others fight it. Some prove to have the ability and desire to achieve and earn recognition in a positive way. A few have character disorders. A few others are fighting so hard for the love of rejecting parents that they can never accept foster family placement. However, nearly all the girls on entering their foster homes are unhappy, anxious, fighting against society, and fighting for unfound satisfactions.

Before entering her new home, the girl has a physical examination and shortly thereafter a dental examination and whatever medical and dental care is necessary. The kind of dental care these girls had previously received is reflected in the fact that most of them have need for extensive dental treatment. Usually, too, their clothing is inadequate and new items are provided. The excitement of having new, attractive clothing, along with the abundance of attention from the caseworker and foster parents, helps the girl to get through the early days.

At the time of placement a clear understanding on the rules of probation is established by three-way discussion between the girl, the social worker, and the foster parents. These rules, which may or may not be written, are simple and few. They include instructions about hours the girl must be at home, her associates—excluding others on probation—school attendance, and, for the older girls, dating. At this time a specific plan for home visiting is also agreed upon. These visits usually are not made until the girl has had a sufficient period of time to allow her to work on her initial feelings about the placement and necessary controls.

In most instances the caseworker accompanies the girl to school and assists her with enrollment and such interviews as may be required with the principal or counselor. When the girl has been in the detention home, the fact that she has been in trouble cannot be concealed, and therefore the caseworker's support is needed both by the unhappy girl and the anxious school personnel. With the frequent histories of school difficulties, getting the girl off to a sound start in the new school is most important.

Foster Parents' Role

The part the foster parents assume in treatment is a demanding one and all-important in bringing about change in the girl's attitudes and behavior, for the foster home is the clinical setting in which growth and change are accomplished.

The foster parents are faced with precocious maturity and sophistication in some areas of the girls' development, and extremely immature, almost primitive behavior in others. They have to give basic training in personal habits such as cleanliness, grooming, care of clothing, and performance of simple household tasks. They also have to give training in the simplest social niceties, consideration for other people, use of acceptable language. To accomplish these tasks they must have an ability to tolerate much, to be patient and accepting, to look at the positives and overlook all but the most glaring negatives, and to be satisfied with small gains.

Foster father and mother teach the girls both by precept and example. For many girls, this is the first exposure to normal, healthy family life in a home where the members love and respect one another and where the parents act with authority that is consistent and unselfish. The foster parents are often the first persons to convey to the girls a feeling that someone thinks enough about them to care what they do.

These foster parents must listen sympathetically but objectively to the girl when she wants to talk, subtly helping her to face reality. They must recognize that she is striving for an affectional relationship with her own parents and that these parents may covertly or openly sabotage their own efforts to help the girl. They must be able to take criticisms from school and community without emotional reactions. They must also be able to accept the social worker's role in supervising the placement, and engage actively in teamwork with the social worker for the girl's benefit. When they do lose patience, or make mistakes, as the best of parents will, they must be able to admit it easily and go on from there.

The foster mothers carry a heavier load than the foster fathers since the mothers are with the girls longer hours and have the basic responsibility for their training. However, the mothers cannot function adequately without the support and help of interested and understanding husbands. Furthermore, because many of the girls have extremely poor concepts of men, the role of foster fathers in helping them to experience relationships with warm, mature, emotionally healthy men is extremely important.

Obviously, no couple can possess all of the ideal attributes for foster parents. However, the worker's understanding of each foster parent's strengths and weaknesses, gained in the study of the home, makes it possible for her to select the most appropriate couple for the girl being placed and to help them use their strengths to the fullest in meeting her needs. All foster parents need recognition, support, and direction in varying degrees.

The Social Worker's Role

The social worker must possess many of the same attributes as the foster parents—patience, warmth, acceptance, interest, firmness, and consistency. She must be able to accept hostility and use authority serenely. In the girl's eyes she is variously confidante, social worker, friend, mother, and truant officer as the girl's moods and needs change. She becomes an object of identification sometimes even to the point of a girl's dreaming of becoming a social worker. But she has an even greater responsibility. She must learn to know, to understand, and to help the girls in relation to their feelings about themselves, their peers, their natural and foster families, their school, and the community at large.

The social worker begins her work with each girl in environmental manipulation—planning for her physical care, placing her in the foster family and in school, arranging for clothing, for an allowance, and for the specific rules and regulations for everyday living. The worker's ongoing contacts with the girl continue to be reality oriented. Regular interviews have to do with day-to-day stresses, demands, and satisfactions. Within this framework, girls are frequently able to reveal much—their concepts of themselves, their families, and authority. They may make comments on a kind of living they have never before experienced and raise questions they have never had anyone they could ask.

The level of communication maintained by the worker is simple and direct, involving frequent repetition. The worker is strongly supportive and is careful to give praise when it is deserved as well as to point out areas where change is needed. The worker supplements the information given by the foster parents to help the girls achieve simple social know-how. Because the girls have little understanding of sex, though they may have had frequent sexual experiences, the worker attempts to help them understand and respect sexual functions. Since the girl needs to experience strong, consistent controls, and to feel that someone cares enough about her to take action when limits are overstepped, the worker returns to court to have the term of probation extended if she breaks the rules in any major way.

As time goes on, the interviews frequently acquire more depth, but the worker does not delve deeper than the conscious level. Psychiatric consultation is available to the worker, and occasionally a girl is referred to a psychiatric clinic for treatment. In preparation for the return home, the worker puts increasing emphasis on helping the girl to recognize and handle the stresses of everyday living, in an effort to integrate the gains made in foster placement. This emphasis on reality factors aids in tapering off the casework relationship.

With responsibility for working with the girl's own parents and the foster parents, the worker's pattern for giving service varies from case to case. In some instances she has many joint interviews with the girl and the foster parents. In others, when the girl may view such interviews as a threat, the worker sees the foster parents alone. The worker tries to see the foster father as well as the foster mother because his positive participation is so essential.

Goals for Parents

The worker's early contacts with the girl's own parents, again both father and mother, are usually focused on plans for placement, consideration of their

ability to contribute financially to their daughter's maintenance, and arrangements for visits to the girl. Subsequently, the worker keeps the parents informed of any changes in plan or of developments in which they may be of help. As planning moves toward the girl's return home, the worker steps up her activity with the parents and during the final months of foster care tries to help them understand how to set and maintain wise limits for their daughter's activities and how to exercise reasonable flexibility in supervising her. Through receiving simple, specific suggestions in ways of functioning as parents, many parents achieve change and find satisfaction in it.

As with the girls, the casework goals for parents must be limited but broad enough to assure the probability of parents and daughter being able to live together more comfortably and constructively than before. Where this does not seem possible, permanent separation becomes the goal and the focus of the casework with parents and daughter alike.

Some Values

This program has suggested that much can be gained by many delinquent girls from being placed in carefully selected foster family homes. The placement gives the girl an experience in normal family living which seems particularly significant in view of the fact that in a relatively short time she may be making a home of her own. It provides one-to-one, group, and community relationships, and a casework relationship of a kind that would probably not be available in an institutional setting. It provides the girl with opportunity for exercising individual responsibility under individualized limits for behavior.

Usually the girl's self-concept is enhanced during her stay in the foster home. She learns a pattern of living that can be transplanted directly into her own home and community, and when she returns home the same caseworker she had while in foster care is on hand to help her with the transplanting process.

Normal maturation, of course, gives a good assist to the success of this program for foster placement of delinquent girls. The younger girls usually do not gain as much as those in their midteens. The latter, for the most part, seem to be more accessible to help and able to change independently of their own families. They also show capacity to respond within a relatively short time.

The first step in helping the girls to change is to break their cycle of acting-out behavior, which they have not been able to do in their own homes. They seem to find it easier to accept limits in a setting where a healthy pattern of living is the established way of life. As their acting out decreases, they become more accessible to help. Through the combined efforts of foster parents and social worker, the pressures on them are relieved and their satisfactions increased. The girls then begin to participate more actively in bringing about change themselves. Not all succeed, and those who make progress do so in varying degrees. Even so, for Judy, and many like her, there may now be a homecoming filled with pride in a "new reputation," with an accompanying ability to maintain it.

In our concern for disorganized youth too many of us base corrective planning on an assumed close relationship between youth and the family circle, as if the major problems of youth necessarily fall within the scope of the family's wisdom and authority.

Actually, the needs that must be answered and the opportunities that must be created for a large proportion of youth—the half-grown—fall well outside the area of family influence. Their family conditioning has been completed for better or worse as early as the fourteenth year, in the case of many of them. What these half-grown youngsters now need is the exertion of a general community influence on the environment around them—an influence that will minimize the evil and maximize the better aspects of that environment.

Lester B. Granger, former Executive Director, National Urban League, to the 1960 White House Conference on Children and Youth.

THE DOCTOR AND THE HANDICAPPED CHILD

ARTHUR H. PARMELEE, JR., M.D.
Associate Professor, Department of Pediatrics, Medical Center, University of California at Los Angeles

THE PHYSICIAN plays a primary part in the development of the child who is handicapped. While he may never have a direct part in the occupational, physical, or speech therapy, or special education the child ultimately receives, he can set the stage for the successful use of these services by the way in which he helps the parents and child accept and work with the handicapping condition. This responsibility rests on the doctor because he is usually the first person to define for the parents the nature and extent of the child's handicap. This important event often occurs in the hospital at the time of birth, if the condition is immediately recognized, or later when the child is admitted to the hospital for observation.

What the doctor tells the patient or his parents about the handicapping condition is certainly important. *How* he tells them and how he and the hospital staff act toward the child or his parents can be critical.

We are constantly expanding our medical knowledge about the causes of various handicapping conditions, and for some conditions we have ameliorative surgical and medical therapy. However, for most handicaps we can only offer partial improvement in the actual physical condition, and for many we have no corrective therapy.

In the latter instances, the child, his parents, and the doctor ultimately have to face the fact that the handicap will be permanently present in some degree and will interfere with the child's normal developmental progress. Obviously this is extremely difficult for the parents and the child, but, perhaps not so obviously, it is also extremely difficult for the doctor. He has to admit that within his chosen profession he is failing because he cannot heal the patient. For this reason, some doctors find it difficult to give up various surgical and medical procedures that often consume a great deal of the patient's time, energy, emotions, and money, and lead to very little functional change in the handicap.

The physician who can accept the fact of his inability to remove the patient's handicap can help the child and his parents to accept it. Then everyone's time, energy, and emotions can be directed toward the best possible adaptation of the child to the everyday world. Some physicians handle this task exceedingly well and others make no effort to cope with it.

We know that doctors often fail to get the parents and their child started in the right direction when the handicap is first recognized. We know this from the reports of parents' complaints. For example, Dr. Koch and associates at the Los Angeles Children's Hospital in a study of the attitudes of parents of retarded children to the medical care received [1] found that parents were critical of what they were told, such as "put the baby away and forget about him," or "there is no hope;" and of what they were *not* told. "My questions about the baby's development were ignored" was a frequent complaint. Dr. Koch found that parents were also critical of *how* they were told about the baby's condition: for example, "The diagnosis was fired at us," "He told us in a cold way," "He was blunt," and "He tried to help, but wasn't informed," or "He wasn't interested in the child."

Such statements indicate not that the doctors

involved were cold, but that they were very emotionally involved because they felt helpless.

These feelings on the part of the doctor have been illustrated by Wilma Gurney [2] in a report written in 1961 of the Child Amputee Prosthetics Project of the University of California at Los Angeles, for which she was then chief social worker.

An obstetrician who delivered one of the babies now in the Child Amputee Prosthetics Project contributed to our understanding. He described his feelings as being very strong and personal, feelings of revulsion and of somehow not wanting to be around the mother. He found himself not wanting to see her or talk with anyone about it.

"After all," he said, "obstetricians don't like this sort of thing. Why do you think we chose this specialty? We don't like stillbirths or abortions, and especially we don't like anomalies."

He went on to compare serious anomalies with other devastating chronic long-term illnesses, saying they were much harder to face than cancer. He explained his thoughts this way:

"Death is really not so terrible. It's the living death that some people have to endure every hour of every day for years that is so devastating. This couple will have to watch their little girl grow up deformed and will be reminded all the time of the heartbreaking difference between her and other little girls."

It is apparent that the feelings about anomalies are strong in doctors as well as parents and can paralyze effective action. Nevertheless, how the doctor talks to the parents and how he conducts himself affects the child's future. Nonverbal is as important as verbal communication.

When Communication Fails

We physicians know that we have failed with parents and their handicapped children when we find that they are not able to accept or use the help of various specialists or special equipment that would be to their advantage. Such children and their parents are still trying to solve the initial crisis of accepting the fact that a permanent handicap exists, of recognizing that hiding from it or having magic dreams will not send it away.

Miss Gurney in another report of the Child Amputee Prosthetics Project at UCLA [3] found that the parents could be divided into three groups:

1. Parents who have sufficiently coped with the traumatic experience of having given birth to a child with an anomaly to be able to discuss the disability realistically; who realize and accept the child's need for both independence and dependence; and who have so freed themselves from self-blame that they can communicate understanding to the child and be helpful to him with his own problems of being different from other children.

2. Parents who are bewildered by the problems that are created by a child who is different; who continue to be troubled by a feeling of having caused the anomaly; who express concern about the reactions of strangers, friends, and relatives to the amputation and to a prosthesis; but who have the strength to look at their reactions and concerns and to make use of help.

3. Parents who have attempted to absorb the child in their own needs and conflicts; or who have isolated the child through avoidance of communication or insistence upon complete self-sufficiency; or who have withdrawn from close association with the family by illnesses or flights into activity; and who in defense deny the need for help.

The children in the first group of families are usually ready to accept a prosthesis immediately and will proceed promptly to learn how to use it. The children of the second group may not yet be ready for acceptance of a prosthesis. Often it is deemed advisable to defer prescribing one for such a child until he has a better understanding of his handicap, but everyone is optimistic that the child and his parents are accessible to help. On the other hand, the children of the third group almost never accept a prosthesis or try to use one correctly. Furthermore, the parents and children tend to reject help with their emotional problems. They are so hard to help at this point that the wisest course is to take steps to prevent this point from being reached.

Dr. Call, a UCLA child psychiatrist, in his report of group meetings with parents of cerebral palsied children,[4] found much the same types of parents' responses to children's handicaps as Miss Gurney. He emphasized the close emotional tie that some mothers developed with their handicapped children, a symbiosis that precluded the child's independent action and self-identification.

We have noticed in working with blind children that when some of them reach the age of 18 months or 2 years, they are still very infantile in behavior, having lacked stimulus from their parents toward any development of independence. Apparently frustrated by their inability to cope with the environment, they have begun to withdraw within themselves. By 4 to 6 years of age, some blind children appear severely retarded and are placed in State institutions where their downhill progress continues. Other blind children have received help early enough to bring them out of this early autism and have gone on to successful school careers. However, many parents of blind children could be helped to avoid letting the children get into such a state. The child has to be accessible to be able to benefit from educational programs for the blind.

What can the doctor do to help prevent some of these problems? He must, of course, define for the parents as clearly as he can the nature of the handicapping condition. Sometimes this is easily done, but sometimes, especially in regard to mental retar-

dation and cerebral palsy, the doctor cannot clearly see the prognosis. He must in any case try to explain, from a medical point of view, why the condition occurred. Sometimes he can do this; most often he cannot. He can, however, listen attentively to the parents' question, "What did we do wrong to cause this?"

And as parents describe some of the ways they feel they might have brought about the condition, the doctor can help them see that these were unlikely causal factors.

Next the doctor must provide the parents with some ways of dealing with the problem over an extended period of time. He must give them ideas and information that will permit several courses of action. The family needs to come to decisions of their own, in due time and in the quiet of their own home. Any abrupt suggestion to "put the child in an institution and forget about him" is ill advised.

Whatever information and help a doctor tries to give the parents should be given unhurriedly. They can only assimilate a small amount at a time. There should be opportunity for daily discussions between the doctor and the parents while the child is in the hospital. The parents and child (if an older child) should feel that they are not alone with their problem and that the doctor is ready to give them encouragement and moral support.

The type of handicap a child has is important in determining not only the management of the child but also the attitude of the parents toward the problem.[1,2,4-7] The age at which the handicap is clearly defined is also important in these respects and carries with it certain similarities for all types of handicaps.

Handicaps Noted at Birth

Physical handicaps noted at birth are for the most part obvious deformities such as congenital amputation of the arms or legs, deformities of the spine (spina bifida), and deformities of the face, including cleft palate and cleft lip, and the more general and sometimes more subtle physical signs of Mongolism.

The parents of the child with an obvious physical defect know immediately that the child will be handicapped in some measure and in the case of congenital amputation are aware that surgical and medical reconstruction will be of partial help only. Such a handicap has a rather sudden finality about it, bringing a crisis for the parents which is immediate and severe. The mother is usually informed of the anomaly before she sees the child, as she should be. But this means she often becomes filled with feelings of self-pity and guilt before she has held her child in her arms and learned to know him as a person. The mother of a child with a cleft palate and cleft lip may have similar feelings, but she usually knows that the condition can be ameliorated by surgery. The mother of the Mongoloid child is, of course, similarly shocked by the knowledge that her child is imperfect, but the deformity is less obvious to her. The probability of mental retardation is only a prediction that she can temporarily disbelieve until time forces her to face the facts.

The common factor in all of these situations is that the mother is told that she has a deformed child before she and the child have had any interpersonal interchange. This confounds the problem of establishing a strong, healthy, mother-child relationship. Miss Gurney has illustrated this:[2]

> What happens to parents following the birth of an abnormal baby? Parents describe this period as living in a nightmare, with only the hope that it is a nightmare from which they will awaken. For those who are not permitted to see their baby, the nightmare is prolonged, making it difficult and even impossible to start dealing with reality. For those who are shown their baby in ways that reveal revulsion on the part of the staff at the sight of incompleteness or deformity, there is an imprint of rejection by persons who should have the greatest understanding of such conditions. For those who are left alone there is the sense of being outcast, of uncleanliness. For those who are fortunate, there is someone who recognizes their sorrow, who handles their baby with tenderness, who says by actions that though this is a disappointing and devastating thing that has happened, the parents are not going to be left to deal with it alone. Universally, parents feel they are alone with a problem that is hopeless.

Fortunately many mothers overcome this difficult emotional situation by virtue of their own emotional strength. Their children develop into successful participants in a prosthetics program, speech therapy class, or special education class. The important point is that many other mothers who might otherwise flounder in their mothering can be helped to establish a strong, healthy relationship with their babies.

It is the seemingly little things that are done in the hospital by the nurses and the doctors that can make the difference. The doctors and nurses who work in the newborn nursery enjoy that pleasant glow that is reflected by the happy mother with a healthy newborn baby. Everyone is upset when a deformed baby appears. The anxiety and depression that affects the staff is transmitted to the mother. This situation is hard to avoid, but there are constructive and destructive ways of handling it.

A common form of destructive behavior is the acting out by members of the hospital staff of their

own anxiety in efforts to "protect" the mother. The mother is not allowed to see the baby until she is "stronger," and no one talks to her about the child's deformity. The baby is placed in a special room and is often overtreated with the use of unnecessary incubators or special feeding techniques. Such behavior emphasizes the enormity of the problem for the mother.

Recently a baby with bilateral cleft lip and palate was born in the UCLA hospital. The inexperienced intern on duty in the nursery was justifiably upset and started to act out his anxiety by overprotecting the mother. We more experienced members of the staff urged him to get the mother and baby together as soon as possible and let the mother give the baby most of the feedings. He was hesitant at first, arguing that the baby weighed only 5 pounds and, therefore, needed special care in the premature nursery, and furthermore, because of the defect in his large palate, the baby would have to be fed by stomach tube.

We pointed out that since the baby was vigorous he would not need an incubator or other special premature care and that many similar babies nursed well from an ordinary nipple. We told him that many mothers consistently cut the rubber palate flap off of the special cleft palate nipples after they get home. The intern deferred to our greater experience, and the mother began giving her baby feedings on the first day, using regular bottles with ordinary nipples. We were all amazed at the ease with which this mother accepted the facially deformed baby and at the skill which she demonstrated in taking care of him.

In this instance we at least did not stand in the way of the development of a good mother-child relationship. We took one further step to try to avoid future problems. We know that this baby will be seen by many doctors and other professional persons in his childhood, such as the pediatrician, plastic surgeon, otologist, orthodontist, audiologist, and speech therapist, and that in a university clinic a patient can become lost in a maze of appointments and a confusing variety of advice. Therefore, we ask the social worker of the pediatric clinic to become acquainted with the mother in the hospital, and to become the mother's liaison with the rest of us. In private practice, the family doctor should play this role, and at UCLA we hope to train doctors to be able to do this well.

What we hope we conveyed to this mother is the idea that she can take care of her child better than anyone else. We also want her to feel that she is not alone and that we will always stand by to help her when she needs us.

Handicaps Noted Later

In such ways the doctor can help the parents of infants whose handicapping conditions are apparent at birth and in doing so help the child. But what about those children whose handicaps only become apparent sometime later during the first 18 months of life? Such conditions as blindness, deafness, mental retardation, cerebral palsy, and some types of handicapping congenital heart disease fall into this category. Because such conditions usually are unsuspected when the baby is in the newborn nursery, it is often possible for the mother and child to have a good and reasonably natural beginning together. But in these instances it dawns on the mother gradually that something is wrong. She then becomes disturbed in her management of the child because he is not following anticipated patterns of behavior. She blames herself for mismanaging the child or the child for misbehaving.

Often when the handicap is finally diagnosed and the mother learns from the doctor of her child's true condition, she is naturally resentful of the time she spent in unnecessarily tormenting herself or her child. She becomes angry with the doctor who did not discover the condition at the onset and with the doctor who did discover the condition but was too abrupt in telling the parents about it. It is a time of many recriminations.

The hospital staff, doctors, nurses, and social workers have to be prepared to accept the overflow of the parents' emotions, including anger, guilt, self-pity, and rejection. The parents need acceptance with all their troubles just as the child does. Too often we who deal with such parents are in a hurry to tell them that the child will do all right if they would only stop acting silly and use some rational common sense. This is desirable but takes time.

There is a natural tendency for such parents to act out their sorrow and feelings of guilt by doing everything for the child, and since the child at this age is still very dependent he has little chance to free himself. A concept to get across to these parents is that they should not prolong or exaggerate the child's dependence on them.

Children who become handicapped when they are older, through accident or illness, present an entirely different problem. They have had several years of normal relationships with their parents, siblings, and

friends. If all has gone well in these relationships, they have a firm emotional background to help them cope with the new crisis of being handicapped. Parents, friends, and doctors are often amazed at the skill with which such children can adapt to a handicapping condition. On the other hand, if the child is already emotionally disturbed and his relationship with his parents is distorted before he acquires the handicap, the new problem only adds fuel to the distorting forces.

In such instances, persons in a professional position must avoid focusing on the handicap in searching for a solution to the child's adjustment problem and must try to keep the child and parents from doing the same. These parents and their child need help with the problems they had before the handicapping condition developed.

The hospital staff can help the child by letting him know by their attitudes that he is just as acceptable with his handicap as he was before. They should accept his sorrow, depression, and anger with understanding, but without indulging in these emotions themselves. The doctor especially needs to represent an understanding and sympathetic pillar of strength that can withstand all emotional onslaughts. From this position, he can help the child and his parents deal with the handicapping condition constructively and keep it in its proper perspective.

In Summary

To recapitulate, no matter what handicap a child has or when it is first recognized, the physician is in a strategic position for preparing the child for later special therapy and education because he is the first to define the nature of the handicap for the parents and the child. The skill with which he deals with this critical moment is of paramount importance to the success of the future adjustment of the child.

In the newborn period, the primary goal must be the development of a healthy mother-infant relationship. The doctor must try to convey to the mother the idea that she can take care of her handicapped child better than anyone else.

In early infancy, the chief problem is the parents' tendency to act out their sorrow by exaggerating and prolonging the dependency of the child. The physician must help the parents see the need for letting the child grow toward independence.

In later childhood, the principal difficulty is to avoid attributing to the handicap problems that existed a long time before the handicapping condition was acquired. The doctor can help the child to understand that he is as acceptable in his handicapped condition as he was before, and to sort out those problems related to his handicap and those related to other factors.

In transmitting healthy concepts to the child and his parents, the physician must be helped by the attitudes and behavior of the entire hospital or clinic staff.

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The growth and development of a child does not wait upon convenience but is determined by the conditions in which his life unfolds. Ours is the twofold task of assuring a future fit for our children and rearing children fit for a future which shall be built upon foundations of justice, security and mercy for all.

Katharine F. Lenroot, former chief of the Children's Bureau, to the Eighth Pan American Child Congress, Washington, D.C., May 2–9, 1942.

THE PROBLEM OF SCHOOL DROPOUTS

IRENE M. JOSSELYN, M.D.
Editor, Journal of the American Academy of Child Psychiatry, Phoenix, Ariz.

THE Scholarship and Guidance Association of Chicago celebrated its 50th birthday in 1961. Those 50 years spanned an era of growing knowledge concerning the psychology of adolescence and the needs of the adolescent. When first organized, one of the major functions of the association, as its name implies, was to provide financial aid to students who otherwise would have been forced to leave school. However, this type of aid from the agency became less important as the availability of public assistance relieved the pressure upon young people to leave school to contribute to the basic needs of their families. While at no time in the history of the agency were the nonfinancial needs of adolescents ignored, the decreased need for its financial assistance and the growth of knowledge concerning the psychology of adolescence led the agency increasingly to use that knowledge to help young people whose emotional problems were interfering with the full use of their capacities.

It is appropriate, therefore, that in evaluating its work after 50 years of development, the agency has undertaken a study of school dropouts in the framework of prevention. The report of the study made by social workers Solomon Lichter (director of the agency) and Elsie Rapien, psychologist Frances Seibert, and psychoanalyst Morris Sklansky has recently been published under the title of "The Drop-outs."*

The cases reported in this book were selected by school personnel on the basis of behavior that suggested that the adolescents involved were potential "dropouts." Because of the criteria used for recognizing this behavior, the book focuses on individuals who might be expected to discontinue school for psychological reasons. These cases provide clues both to certain psychological constellations that may lead a young person to drop out of school as soon as the law permits, and to extremely interesting illustrations of constructive approaches to certain types of potential dropouts.

The psychological constellations observed in this group of cases are similar to those that might be observed in any cross section of emotionally disturbed persons of any age. But among adolescents there appears to be higher frequency than in other age groups of the utilization of escape when a conflict arises which is rooted in any of these constellations. Too many adolescents, for example, who are hostile toward authority, rebellious against it, or feel trapped by it attempt to deal with these feelings by escaping from the authority of the school, only thereby to expose themselves to the authority of job foremen. They are unable to strive for the long-time goal of equipping themselves for work in which they would be required to bow in authority. Likewise, in instances in which there is a need to be defiant, the adolescent too often chooses the escape pattern of leaving school rather than a pattern which would not make it necessary for him to lose the benefits from schooling.

The escape aspect of the adolescent's response accents the importance of instituting therapy with the disturbed adolescent before he reaches the age at which he can legally choose actual escape from school in his efforts to handle this conflict. Thus, the urgency of helping adolescents to resolve such conflicts derives not solely from the nature of the conflict; in fact, the resolution of adolescence in

*Lichter, Solomon; Rapien, Elsie; Seibert, Frances; Sklansky, Morris: The drop-outs. The Free Press of Glencoe, New York. 1962. 302 pp. $5.50.

many cases might itself erase the conflict's most crippling aspects. However, if an adolescent attempts to resolve the conflict by discontinuing his education, this solution may have a more seriously crippling effect on his future than would an inadequate resolution of the conflict.

The effectiveness of therapy while the young person is required by law to be physically present at school is impressively described in "The Drop-outs." The book documents the belief that the disturbed adolescent can be helped to understand his problems, to find a more constructive solution to them, and to alleviate some of the modifiable situations which have created the difficulty. I suspect, however, that understanding the conflict, a redirection of its solution, and alleviation of its reality components may not have been the main forces which modified the behavior of the adolescents the book describes.

Often when his action is the result of some emotional conflict, an adolescent consciously knows the nature of that conflict. His insight in regard to the conflict only supports the act that expresses it. In such cases this negative use of insight can be modified only when the adolescent is able to accept a meaningful relationship with an adult who understands the nature of the psychological difficulty. Although the positive nature of the client-therapist relationship is discernible in the therapy reported in "The Drop-outs," it is perhaps not sufficiently stressed. Possibly the insight the therapist had into the emotional difficulty of the adolescent was at least as significant as the adolescent's own insight.

Some Omissions

Because of the criterion used for the selection of cases to be studied, there were two types of cases omitted in this report: potential dropouts who are limited in intellectual ability; and the "covert dropouts."

The adolescent who has a below-average learning rate requires us to look at this question: What is the validity of a compulsory educational law which requires a young person to remain in school even though the only further learning he can be expected to acquire is how to sit quietly, listen, and make a pretext of grasping subjects that are beyond his ability to comprehend? Such a learning experience may lead to a psychological handicap in adult life as serious as the loss of education is to the individual who can profit by education.

The authors by omitting the intellectually marginal group of adolescents were able to avoid the question of how a community can enable such young people to make an optimum contribution to society and to gain more self-gratification. Until areas of possible educational expansion to benefit such young people are identified and suitable programs provided, "the stay-in-school" of this group may be as seriously handicapped, though less obviously so, when he becomes an adult as the "dropout" who has superior learning ability.

The "covert dropouts," another group of young people who should be considered under the broad category of "dropouts," are referred to only indirectly in this report. They are individuals who remain in school and learn their lessons, but though they learn the tools for future work or the subjects that will enable them to gain tools for their future work from college attendance, they are not educated. The many reasons for this failure to become "educated" are closely related to those which cause other bright youngsters to drop out of school. In addition, there is probably another rather obvious factor involved—the goals of education as presented to the young person by adults. If keeping a child in school as long as he can profit from formal education is valid, should we not consider the effect on young people of our most frequent argument for school attendance?

Young people are told that the more schooling they have, the better, and especially the more financially remunerative, the job will be that is available to them. Thus the diploma and not what the diploma represents becomes the aim of the student as he remains in school, and the high-paid position his goal on graduation. While it is important to encourage every young person to acquire tools for his future work and thus for establishing his vocational and social identity, such a goal only provides a passport into adult life. It does not make him an adult.

The current criticism of today's college graduates as materialistic and self-focused in their selection of careers and positions seems to fit a large number of young people. This calls for recognition of the fact that in addition to the numbers of overt dropouts from high school, about whom figures are frequently released, there are a great many covert dropouts. The latter, at least, are available to educate since they remain in school. But the problem of relating education to greater depth and breadth of living is not touched upon in the book, "The Drop-outs."

The book does bring out the necessity of the therapist cooperating with the school and the school cooperating with the therapist in working with

potential dropouts. The authors found the schools very willing to tolerate disturbed behavior, to modify their approach to the student who was under treatment, and to wait for results as long as they were aware of the fact that therapy was being undertaken and were kept abreast of developments.

Too often the therapist who is interested in working with an individual in isolation from the rest of his life unconsciously shares the adolescent's resistance to parents and school authority. Under the dignified robe of therapist he, himself, is a "drop-out." In some cases at least, the therapist's isolation from the school probably either enables him to ignore the vicarious gratification he gains through his client's or patient's resistance to school or enables him to utilize his understanding of the young person to consolidate his own hostile, rejecting attitudes toward adults. In such instances, the adolescent and therapist share a negative point of view, even though the therapy may seem to be successful because the young person stays in school. In the cases presented in "The Drop-outs," this type of isolated therapy has been avoided.

However, the authors of "The Drop-outs" labored too hard to identify the problems their young people presented according to psychoanalytic phase differentiation. When the cases are described and discussed rather than labeled, they become alive; they lose some of their aliveness as they are redefined in what apears as rather stultifying use of psychoanalytic terminology. Fortunately the real value of the study is not masked by such terms.

The study offers an opportunity to examine certain important facets of the question as to why students of average and above-average intelligence with no financial need to begin working leave school as soon as they legally can, in spite of pressure from home and school not to do so. It stresses the emotional problems that the young person anticipates he will solve by leaving school. Thus, it is a study of a symptom—discontinuing school—which like so many symptoms may have any number of causes. The emotional problems which produce this symptom may in other adolescents produce other symptoms, for it is characteristic of emotional problems that their symptoms vary. Therefore, the elucidation of the emotional difficulties of adolescents as presented in this book provides an understanding of adolescents in general and not just the adolescent who will leave school.

GUIDES AND REPORTS

SEPARATION ANXIETY: A CRITICAL VIEW OF THE LITERATURE. John Bowlby, M.D. Child Welfare League of America, 44 East 23d Street, New York 10. 1962. 20 pp. 60 cents.

A reprint of an article that appeared in the February 1961 issue of the *Journal of Child Psychology and Psychiatry.*

SOCIAL WORK PRACTICE IN THE HEALTH FIELD. Harriett M. Bartlett. National Association of Social Workers, 95 Madison Avenue, New York 16. 1961. 285 pp. $3.50.

An analysis of social work practice in general and in health agencies, with a comparison of methods used by this discipline and others in the health field.

THE YOUTH QUESTION: IS IT A PROBLEM AND FOR WHOM? R. Alex Sim; and A CRITICAL LOOK AT YOUTH SERVICES IN THE 1960's. Joseph Laycock. Selected Papers No. 4 from the 41st annual meeting and conference of the Canadian Welfare Council, May 29–31, 1961. Canadian Welfare Council, 55 Parkdale Avenue, Ottawa 3. 1961. 24 pp. 50 cents.

Two papers from the conference which had the overall theme: "Social Policy in the Sixties."

GUIDE TO THE CONTENT OF SECOND-YEAR FIELD TEACHING IN CASEWORK. The Committee on Content, School of Social Service Administration, University of Chicago. The University of Chicago Press, Chicago, Ill. 1961. 42 pp. 75 cents.

With the purpose of assuring a basic core of field-work instruction to all students, regardless of setting or individual instructor, this pamphlet was prepared by a committee consisting of field-work instructors and consultants from various settings, and presents the committee's findings on the generic content of what is taught in the school's course for second-year field work.

PEDIATRICS AS A CAREER. American Academy of Pediatrics, 1801 Hinman Avenue, Evanston, Ill. 1962. 18 pp. Free on request from the Academy.

Designed for premedical and medical students and interns, this illustrated pamphlet discusses pediatrics in relation to disease prevention, mental hygiene, juvenile delinquency, the growth and development of children, congenital malformations, prenatal events, care of the newborn, serial health examinations, and pediatric subspecialties.

BOOK NOTES

THE CULTURALLY DEPRIVED CHILD. Frank Riessman. Foreword by Goodwin Watson. Harper & Bros., New York. 1962. 140 pp. $3.95.

To exploit the vast reservoir of intellectual talent among culturally deprived children that lies "virtually untapped" in public schools tuned to middle-class norms, Dr. Riessman, chairman of the psychology department of Bard College, challenges school systems to take into account the culture of lower economic groups and the mental styles it produces among children.

He draws on a number of studies to show that deprived children from underprivileged groups are educable and tend to be physically and visually oriented; inductive rather than deductive in thinking; slow, careful, and persevering in important matters; and though handicapped in verbal expression, able to display an inventive word-power of a kind unappreciated in school. Deficient in school "know-how," they tend to be slow learners who favor the three R's and science over art, music, and the social sciences, the author says.

One of the book's 12 chapters brings into relief some positive qualities in the culture of deprived groups—their stress on ruggedness and vigor, cooperation, family cohesion, and informality, and their warm humor—all of which the author says can be helpful in promoting learning.

The final chapter, "Ideas for Action," urges teachers and others working with deprived children to study their background, especially its positive elements, look for hidden IQ's, give more attention to slow learners, and develop their reading skills as well as their ability to take a test.

In a roundup of suggestions for teachers taken from his own and others' works, the author includes development of special education for teachers of deprived children, lengthening college programs to 5 or 6 years for slow learning students, teaching in traditional ways rather than through "progressive methods," and "masculinizing" the schools because the current stress on feminine values conflicts with these children's culture norms and inhibits their development.

Throughout the book the author stresses the point that adults must respect these children in order to help them to learn.

BEHAVIOR AND DEVELOPMENT FROM 5 TO 12. Glenn R. Hawkes and Damaris Pease. Harper & Bros., New York. 1962. 375 pp. $5.75.

The "middle years" of the child and his world are described by the authors, both of whom are affiliated with the Department of Child Development at Iowa State University. The concepts presented are based on research and observations from the biological, social, and behavioral sciences, and are illustrated by excerpts from case histories and pertinent literature, and by graphs, charts, and photographs.

The physical, emotional, social, and intellectual growth of the child are discussed along with material on family, school, peer group, community, and the impact on youngsters of the mass media of communication. The book closes with a chapter on techniques for observing and recording child behavior, a summary of behavioral characteristics of youngsters at different ages, and a "preview" of adolescence.

An extensive appendix contains an annotated bibliography of films and publications.

SCHOOL VOLUNTEERS. T. Margaret Jamer. Public Education Association, New York. 1961. 200 pp. $3.95. ($4.10 postpaid.)

In introducing this record of the experience of an organized volunteer program operating in some of New York City's public elementary schools—to help offset the effects of crowded classrooms and overworked teachers—the author, who is the program's director, points to the "waste of human potential" that comes from inadequate education in the early years. Such inadequacy, she maintains, is "seldom overcome in high school." The book depicts the way trained, supervised volunteers relieve teachers of routine and extracurricular chores to free them for fuller attention to teaching; rescue hundreds of children from an "educational no-man's land" by giving them individual help, sometimes in reading; and enrich the children's lives in art, crafts, music, languages, dramatics, journalism, and creative writing.

After outlining the organization of the program by the Public Education Association (inspired in part by a 50-year-old London experiment), the author turns to the program's development, reviews recruiting and operating procedures, describes the variety of volunteer tasks, and appraises the program. She also gives advice on staff-volunteer relations and coordination, and optimum numbers of volunteers (30 to 50 with a volunteer chairman per school). A generous number of illustrations, including samples of forms and questionnaires for staff and volunteers, contribute toward the expressed purpose of this book: a guide for other communities and potential volunteers.

CREATIVITY AND INTELLIGENCE: explorations with gifted students. Jacob W. Getzels and Philip W. Jackson. John Wiley & Sons, New York. 1962. 293 pp. $6.50.

The distinction between creative and intelligent thinking has been lost in the rush to apply the intelligence test as a metric by which "individuals are evaluated and sorted, given preferment or denied it," according to the authors of this book, two educational psychologists, both with the University of Chicago. The book reports on their explorations, during 1957–59, of creativity and its relation to intelligence. These were made by comparing two groups of pupils (totaling 449) in the junior and high school grades of a Chicago private school. One group, high in creativity, did not test high in intelligence, and the other, with high intelligence scores, did not make high scores on creativity tests.

Three of the book's five chapters present profiles of the two groups, inter-

laced with theories regarding giftedness. They show, for example, that the young people in the creative group, though achieving as well scholastically (but not in popularity with teachers) as those in the other group, had more humor and openness in self-expression—more self-confident and tolerant parents and less specialized family occupations—and less achievement-motivation and precision.

Another chapter reports on a similar study of the sample in relation to "morality"—defined as involving seven specific traits including identification with humanity and holding to personal ideals regardless of social pressures—and social adjustment or psychosocial functioning, judged by such traits as relative freedom from morbid fantasy, defeatism, and hostility. Of two groups, one scoring high in "moral" qualities but low in adjustment, and the other showing the reverse scoring pattern, the "moral" group revealed, among other things, greater concern with "becoming," and the socially adjusted, greater concern with "being."

In the final chapter reports on clinical studies of several pupils are followed by descriptions of the study's instruments and procedures.

The authors suggest that ways be sought for society to reward rather than penalize independent thinking and other expressions of creative valor.

ESSENTIALS OF PEDIATRIC PSYCHIATRY. Ruben Meyer, M.D., Morton Levitt, Ph. D., Mordecai L. Falick, M.D., and Ben O. Rubenstein, Ph. D. Appleton-Century-Crofts Division, Meredith Publishing Co., New York. 1962. 208 pp. $6.

For the pediatrician, whose work, according to the authors, has become concerned less and less with therapy and more and more with prevention and questions of child rearing, learning problems, phobias, and other emotional disturbances, this volume outlines some basic knowledge about the normal psychic development of infants and children and their emotional problems—to serve as a model on which he can "flesh in" from his own experience.

Drawing attention to the ways in which psychiatry and pediatrics have cross-illuminated each other and the high degree of compatibility between the two disciplines, the team of authors, who are faculty members of the Wayne State University College of Medicine in Detroit, present first the broad lines of psychic development, according to psychoanalytic theory. Then they proceed to describe, in addition to the manifestations of normal development, children's emotional reactions to trauma and hospitalization, serious disorders of development, ways of evaluating borderline and pathological cases, and when and where to refer patients.

According to the authors, the material is "neither eclectic nor extensive," but rather selective of areas that are of major concern to pediatricians.

DIALOGUES WITH MOTHERS. Bruno Bettelheim. Free Press of Glencoe, New York. 1962. 216 pp. $3.50.

Dr. Bettelheim, director of Chicago's Orthogenic School, presents here a series of selected tape recordings of parent education meetings he conducted over a period of several years with a group of young, normal mothers whose husbands were students at the University of Chicago, and who brought him the kind of child-rearing concerns common to mothers in a middle-class, upwardly mobile group.

Rather than advising the group participants, Dr. Bettelheim attempted through discussion to bring out the observations, knowledge, and insights of the mothers themselves. This book is intended primarily for parents whose background is similar to those who took part in these discussions.

BASIC ANXIETY: a new psychobiological concept. Walter J. Garre. Philosophical Library, New York 16. 1962. 123 pp. $5.

The genesis of diffuse anxiety in humans, according to this author, goes back to a "basic anxiety" which he says is felt by all infants in varying degrees depending on the degree of rejection, or seeming rejection, of the infant by the mother or mother substitute—an anxiety rooted in a fear of destruction, abandonment, or of being unprotected in the face of danger. The author, who is Chief of Psychiatry of the Veterans' Administration in San Francisco, attributes most human dysfunctioning in what he calls the physical, "social-mental," reproductive, and economic spheres to overreacting on the individual's part. For example, he maintains that overstimulation of the peptic juices is a result of early fear of abandonment and thus of starvation, and that chronic fatigue comes from excessive outpourings of energy in reacting to the continued presence of "basic anxiety" throughout life.

Because this loss of energy draws off ego strength, the author suggests that the more emotional investment the child originally receives from his parents, the more ego strength he will attain as an adult and will be able to pass on to his own children. The emotional capacity of a family remains constant from generation to generation, he concludes, adding the suggestion that the familial occurrence of deficiencies is not due to defective germ plasma, but to "unconsciously conditioned selective mating."

ACCIDENT PREVENTION: the role of physicians and public health workers. Prepared under the direction of the Program Area Committee on Accident Prevention for the American Public Health Association, with the cooperation of the Public Health Service, Department of Health, Education and Welfare. Maxwell N. Halsey, editorial consultant. The Blakiston Division, McGraw-Hill Book Co., Inc., New York. 1961. 400 pp. $12.

This book, directed primarily to physicians and public health workers, presents a comprehensive view of the total field of accident prevention.

Chapters are devoted to the magnitude and epidemiology of the overall problem, and to the problems of special age groups—children and the aged. Other chapters are concerned with safety in specific settings—the home, farm, school, traffic, industry, recreation, and even industrial fleet driving and private flight. Safety activities are also discussed from the point of view of the physician's role, programs for medical societies, and programs for public health agencies. Chapters on emergency care, professional education, factfinding, and research complete the presentation.

Under the general direction of the American Public Health Association Committee on Accident Prevention, each of these chapters has been contributed by a leader in the safety field.

HERE AND THERE

Public Welfare Amendments

On July 25, President Kennedy approved the Public Welfare Amendments of 1962 which he described as "the most far-reaching revision of our public welfare program since it was enacted in 1935." The new law, Public Law 87–543, amends both the public assistance and the child welfare provisions of the Social Security Act.

The child welfare provisions (title V, part 3) are amended to provide for:

- Increases in the Federal funds that can be appropriated for grants to the States for child welfare services from $25 million to $30 million for fiscal 1963, $35 million for fiscal 1964, $40 million each for fiscal 1965 and 1966, $45 million each for fiscal 1967 and 1968, and $50 million per year thereafter.
- Clarification, and some broadening, of the purposes for which such grants may be used, through a definition of child welfare services.
- The earmarking of a portion of the funds appropriated under the increased authorization for the provision of day care services. The maximum amount so earmarked is not to exceed $5 million in fiscal 1963 or $10 million thereafter. The earmarked funds are to be allotted among the States on a formula basis, with a minimum allotment of $10,000 per State per year.
- Grants to institutions of higher learning for special projects for training personnel in the field of child welfare. These projects may include traineeships.

As conditions of plan approval, effective July 1, 1963, each State's child welfare services' plan must show—

- Coordination between the services provided under it and those provided for children under the State's plan relating to dependent children under Title IV of the Social Security Act.
- Provision for extending child welfare services throughout the State, so that by July 1, 1975, they are available to all children in need of them. State and local child welfare services' staff, to the extent feasible, are to be trained child welfare personnel, and, in extending service, are to give priority to communities with the greatest need.

If day care services are to be provided, the plan must include—

- Cooperative arrangements with the State health and education agencies, to assure maximum use of these agencies in the day care program; a State advisory committee on day care; safeguards to assure that day care is used only in the best interests of the child and the mother; provision for payment of reasonable fees by the family when appropriate; and arrangements for giving priority to members of low income or other groups having the greatest need for day care.

Needy Children

The amendments affecting public assistance include significant changes in the aid-to-dependent-children program (title IV), the name of which was changed to "aid and services to needy families with children."

One extends for 5 more years the Federal-State program of aid to children of unemployed parents which expired on June 30; and another makes permanent the temporary provision allowing Federal participation in the cost of foster family care of children who are recipients of assistance. To the latter has been added a provision for Federal participation for the next 2 years in payments for foster care in nonprofit, private child care institutions.

Other amendments to title IV allow Federal participation in—

- Payments which include provision for a second parent who is living in the home and is incapicitated or unemployed.
- Payments to recipients for work performed in community work and training projects of a constructive nature, if certain safeguards to protect the recipients and their children are met.

Among the required safeguards in this provision are: appropriate health and working conditions, including health and safety standards and protection under the State's workmen's compensation law; rates of pay which are no lower than the State's legal minimum and the prevailing community rates; opportunity for the worker to seek regular employment and to receive any available and appropriate training; allowance for expenses appropriate to work in determining the family's need. The States are also required to make maximum use of the job-placement facilities of the State employment service and of the retraining programs of the State vocational education and adult education programs; and to make sure that appropriate arrangements for the care of the worker's children have been made. Recovery by the State of payments made for work accomplished is prohibited, as is denial of aid to persons for refusal with good cause to perform work.

This provision has a 5-year limit before the end of which the Secretary of Health, Education, and Welfare is to prepare a report on the experience under it for Congress.

- "Protective payments" made to a person other than the caretaking relative in instances in which the State welfare department determines that the inability of the caretaker to manage funds is such that the well-being of the child is adversely affected.

The number of individuals for whom such payments may be made in a month is limited to 5 percent of the number of other recipients under the program, and again a number of safeguards are required, including provisions for: continuous effort to develop the caretaker's ability to manage; periodic review of the situation and the appointment of a legal guardian if after a specified period of time the caretaker is still unable to do this; an opportunity for the caretaker to have a fair hearing.

To be eligible for Federal participation in protective payments, the States must have foster home care provisions in their plans for aid and services to needy families with children.

Another amendment to the act provides for the appointment of an advisory council by the Secretary of Health, Education, and Welfare in 1964 to review the administration of the public assistance and child welfare programs and to report its findings and recommendations by July 1, 1966. The council is to be composed of 12 persons

representative of employers, employees, State or Federal agencies which administer or finance public welfare programs, private welfare organizations, the public, and persons with special knowledge or experience.

Other amendments to the act authorize Federal funds to encourage States to provide rehabilitation services for public assistance recipients; and provide for the use of Federal funds for the direct training of workers capable of giving such services as well as for stipends and scholarships.

CB Appropriations

As finally passed by both Houses of Congress in late July, the Children's Bureau appropriation for fiscal 1963 included $2,853,000 for salaries and expenses—an increase of almost $200,000 over the amount for 1962. It also included $75,795,000 for grants to the States under Title V of the Social Security Act. This includes $25 million for each of the three programs of grants to the States under this title—maternal and child health services, services to crippled children, and child welfare services—and $795,000 for grants for research or demonstration projects in the field of child welfare.

The appropriation for child welfare services represents an increase of $6,250,000 over last year's amount, and the appropriation for research or demonstration projects in this field, an increase of $520,000.

Refugee Assistance

In late June, Congress passed the Migration and Refugees Assistance Act of 1962, placing in a single vehicle the previously diffuse Federal authority to assist political refugees from other lands. The act authorizes appropriations for assistance and services to refugees who "have fled from any area in the Western Hemisphere and cannot return thereto because of fear of persecution on account of race, religion, or political opinion." Funds for such aid, as in the Cuban refugee program, have up until now been drawn from the President's contingency fund. (See CHILDREN, May–June 1961, p. 116.)

The act's definition of "refugee" now makes it possible to extend aid under the Cuban refugee program to persons who had fled to Cuba as political refugees and who have recently come to this country for asylum. Such persons did not qualify for aid under the directive which originally established the Cuban refugee program, as this was limited to Cuban nationals.

The act also carries provisions for contributions of the United States to activities of United Nations High Commissioner for Refugees.

International Planning

The 1962 meeting of the Executive Board of UNICEF, held in June, marked the completion of the first year of new policies leading to an expanded program. (See "Future Directions of UNICEF," by Maurice Pate, CHILDREN, September–October 1961, p. 191.) Among the new types of projects approved for aid were six in the field of education—two in Africa, two in Asia, and two in the Eastern Mediterranean. Five are focused on training teachers for primary schools; the sixth (in the Congo, Léopoldville) is aimed at an immediate increase in enrollment in secondary schools with concurrent efforts directed to teacher training. In each case, the curriculum will be reoriented toward the real-life prospects of the child. In primary education programs in Iraq, Thailand, and the Congo, stress will be placed on teaching practical skills, particularly for the improvement of nutrition and health education.

UNESCO will be closely associated with UNICEF in the implementation of these projects, as it was in their planning. Attending the meeting was the chief of UNESCO's Department of Education who expressed satisfaction in seeing UNICEF turn toward developing the mind as well as the body of the child, and the hope that the trend would become even stronger in the future. He particularly stressed the need for training teachers of teachers.

The Board also approved projects in Chile, Costa Rica, and Haiti for vocational training for out-of-school youth, which the International Labour Organisation has helped develop. A representative from the ILO pointed out that this kind of assistance has the value of opening new horizons for those who will in the future contribute to the stronger economic and social organization of their countries.

Aid in the field of child welfare services was increased from commitments of $400,000 in 1960 to $1,500,000 in 1962. It is anticipated that this type of aid will increase to about $2.5 million in 1964.

The bulk of UNICEF aid will continue to go for the establishment of programs in the fields of health and nutrition. A total of 124 projects were approved, amounting to about $16.5 million.

A major part of the Board's discussion focused on the need for considering children in planning for national development. A report on this subject submitted by the executive director pointed out that little planning for children is being done in most developing countries, and stressed the need to recognize social development as an essential partner of economic development. Throughout the discussion, it was made clear that UNICEF is prepared to assist countries in reviewing their children's needs and in making comprehensive plans to meet them.

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The importance of close association of plans for social and economic development also received major attention at the spring meeting of the United Nations Social Commission (April 30–May 11), which passed resolutions urging, among other steps, the preparation by the Secretariat of guidelines for the use of governments for the allocation of resources to various social programs at different stages of economic development; the inclusion of social as well as economic planning in the establishment of regional development institutes; and the use of such institutes to advise governments on problems of integrating economic and social planning. The Commission also urged increased support for technical assistance projects in the field of housing and for other U.N. programs in the social field; and recommended that the Economic and Social Council set up a special committee on housing.

Child Abuse

A suggestion that the States require physicians and hospital administrators to report cases of suspected physical abuse of children by adults was made in late May by a group of lawyers, juvenile and family court judges, probation officers, doctors, and social workers, called together by the Children's Bureau to consider action to protect "battered children."

The 1-day meeting was the outgrowth of the Bureau's January 15 conference

on the abused child which recommended that legal aspects of the problem be given technical consideration. (See CHILDREN, May-June 1962, p. 123.)

A law making such reporting mandatory on physicians and hospital administrators would be helpful, the group suggested, since these professionals "are bound by law as well as by professional ethics to respect the confidentiality of the professional relationship." Such a statute, the group agreed, should relieve the doctor or hospital administrator from liability to charges of slander or libel arising from the reporting. In addition, it should specify what to report, and to whom the report should be made.

What to report, the group agreed, should probably be described in such general terms as an injury which the person making the report has reason to believe was inflicted on the child by a parent or caretaker.

Each State would have to decide for itself to whom the report should be made, the group pointed out, the majority specifying a preference for law enforcement bodies and a minority social agencies having protective functions.

A draft of a model statute embodying the proposal is now being developed by the Children's Bureau. It will be circulated for comment among members of the legal profession, law enforcement officers, pediatricians, hospital administrators, social workers, and others concerned with child health or welfare before being put in its final form.

Juvenile Delinquency

In July the President's Committee on Juvenile Delinquency and Youth Crime announced 21 grants for training personnel to prevent and treat juvenile delinquency and youth crime. Like the four training grants made previously (see CHILDREN, July–August 1962, p. 164), these grants were made to support university training centers, short-term workshops, and the development of new training materials and techniques.

The universities to receive training center grants are: the University of North Carolina, $153,744; the University of Utah, $150,000; the University of Washington, $112,488; Wayne State University, $152,201; and Western Reserve University, $151,500.

The following organizations received grants for workshops: Civic Center Clinic, Inc., Brooklyn, $800 for 10 workshops for court, probation, and parole workers, gang workers, and representatives of the Division of Vocational Rehabilitation and the New York State Employment Service; the Hunter College School of Social Work, $69,940, for a series of staff development workshops; the National Council on Crime and Delinquency, $80,470, for a series of regional institutes for parole board members; the Kings County Court, Brooklyn, $12,135, for three annual 5-day institutes for college teachers to be given experience by probation officers; the Department of Institutions, Washington State, $5,616, for a series of workshops for State youth workers; and the St. Louis University School of

PROGRESS IN REDUCING INFANT MORTALITY

Deaths under 1 year per 1,000 live births

Countries ranked on 1961 rate	1961		1950		Percent decrease since 1950
	Rank	Rate	Rank	Rate	
Netherlands	1	*15.4	3	25.2	38.9
Sweden	2	*15.5	1	21.0	26.2
Norway (1959)	3	18.7 (1959)	5	28.2	33.7
Australia	4	19.5	2	24.5	20.4
Finland	5	*19.8	11	43.5	54.5
Switzerland	6	*20.8	8	31.2	33.3
United Kingdom	7	22.1	9	31.4	29.6
Denmark (1959)	8	22.5 (1959)	7	30.7	26.7
New Zealand	9	22.8	4	27.6	17.4
United States	10	*25.3	6	29.2	13.4
Canada (1960)	11	27.3 (1960)	10	11.5	34.2
Japan	12	28.8	15	60.1	52.1
Ireland	13	30.5	13	46.2	34.0
Luxembourg (1960)	14	31.5 (1960)	12	45.7	31.1
Federal Republic of Germany	15	*31.7	14	55.6	43.0

(*provisional)

The countries in the above table are those with populations over 300,000 which are known to use the World Health Organization definitions of live birth and of infant death, and to have relatively complete reporting.

Among these countries, the Netherlands, Sweden, and Norway now have the lowest infant mortality rates, according to the latest available figures. Only 4 of these countries had rates in 1961 under 20 per 1,000, notably the Netherlands, Sweden, Australia, and Finland. The United States, with a provisional rate of 25.3, continued to rank 10th as it has in recent years, showing a drop from the 6th place it occupied in 1950. Of countries with relatively low infant mortality rates in 1950 (under 30 per 1,000), the largest gains in percent reduction in rate by 1961 were accomplished by the Netherlands, Norway, Sweden, and Australia. Relative gains since 1950 were smallest in the United States and in New Zealand.

The provisional infant mortality rate recorded for the United States in 1961 is about 15 percent higher than the rate in the United Kingdom, and about 63 percent higher than in the Netherlands and Sweden. If the rate in the United States were no higher than in the Netherlands and Sweden, infant deaths in this country would number 42,000 fewer for the year.

The sources of the above data are the United Nations, Statistical Office, and the U.S. Department of Health, Education, and Welfare, National Vital Statistics Division.

Social Service, $84,975, for inservice training of juvenile court, probation, and parole personnel, teachers, youth counselors, and social workers; and for educational and group work services for parents of children under juvenile court supervision.

Ten grants to develop training materials went to the Citizens' Committee for Children of New York, the International Association of Chiefs of Police, and seven universities.

The committee also recently made additional grants for planning community demonstration projects to combat juvenile delinquency. These went to the Minneapolis Health and Welfare Council, $149,845; the Youth Opportunities Board of Greater Los Angeles, $252,906; the Philadelphia Council on Community Advancement, $165,000; the Chicago Commission on Youth Welfare, $292,000; the District of Columbia Board of Commissioners, $100,767; the Detroit Commission on Children and Youth, $202,200; and the Harlem Youth Opportunities Unlimited, New York, $230,000.

Radiation

Recommendations for expanding the Nation's network of radiation surveillance centers and for intensifying research and development of methods in radiation control were made by the National Advisory Council on Radiation in a report released in June by the Surgeon General of the Public Health Service.

Created in 1958 to advise the Surgeon General on control of radiation hazards, the council urged in its report the coordination of public health and related resources at the Federal, State, and local levels, for an integrated national effort.

The report points out that countermeasures developed to control environmental contamination should meet the criteria of being practical, effective, and safe; responsibility for their application should be clearly defined; and research on countermeasures should be directed to methods that improve the safety of radiation sources, control vectors of radiocontamination, and minimize or prevent harmful effects of radiocontaminants admitted to the body.

Specific countermeasures are discussed at some length in the report. Recommended for radioactive iodine, iodine 131, in the event dose levels of this product of radioactive fallout rise high enough to warrant countermeasures, is the use of powdered or evaporated milk for infants and pregnant and lactating mothers. The report describes iodine 131 as one of the most important short-lived radiocontaminants gaining entry into the human body mainly through ingestion of dairy products. It concentrates in the thyroid gland and may cause physical damage, especially to infants and young children. Countermeasures for strontium 90—long-lived and introduced into almost all kinds of food via contaminated soil—are also considered, primarily in relation to soil-content and diet changes.

Other recommendations that are set out in the report concern training radiation health specialists and expanding the Service's budget for radiological health efforts in research and development, Federal-State programs, and countermeasure activities.

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A technique for removing radioactive iodine from milk developed by radiation chemists in the laboratories of the Public Health Service was described at a meeting of the American Dairy Science Association in June at College Park, Md. The process, which has been accomplished on a laboratory scale only, involves passing raw milk through columns containing special resins that attract and hold the iodine. This is an application of a similar process using a different resin to remove radioactive strontium from milk, under development for the past few years in a joint project of the U.S. Department of Agriculture, the Public Health Service, and the Atomic Energy Commission.

The announcement of the new process, described as capable of removing 95–98 percent of radioactive iodine from fallout-contaminated milk, came shortly after reports in May that the radioactive iodine level in pasteurized milk sampled that month at Public Health Service radiation surveillance stations in 12 Midwestern States, including stations at Wichita, Kans., Kansas City, Mo., showed a sharp increase. Though these increments were believed to be transient—resulting from the Pacific atomic tests—sampling in these Midwest areas was increased from the usual weekly schedule to twice weekly. In June, sampling showed a substantial decline in most of the affected areas.

For places with the highest radiation levels, the service made plans to gather additional data. In late June, 10 children accompanied by parents were taken from Kansas City and 10 from St. Louis to the New York University-Bellevue Medical Center for studies of the amounts of radioactive iodine retained by the thyroid gland in relation to the amount they had consumed in milk (or, with the St. Louis children, in their total diet) for 10 days prior to leaving for New York. Under Public Health Service sponsorship, the children and parents, who are members of families of Federal and local health department employees, were tested with specially designed equipment for measuring low-level gamma radiation in the human body.

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According to data collected over 4 years at the University of Michigan Medical Center, to gauge the effect of radioactive fallout on the thyroid glands of unborn children, the amount of radioactive iodine in fetal thyroid glands during the 3 months, December 1958, January 1959, and May 1959, topped the "maximum permissible level" of 130 micromicrocuries ($\mu\mu$c.) without any apparent ill effects. In each of these months the level of 180 $\mu\mu$c. was reached. The concentrations fluctuated markedly from week to week during periods of bomb fallout, and varied widely from one person to another.

The medical center began work on the problem while seeking a clue to the cause of cretinism, a disorder marked by underactivity of the thyroid gland. This gland concentrates the iodine in the body and, according to the director of this study, Dr. William H. Beierwaltes, in the fetus it collects iodine more vigorously than in adults. He estimates that the fetus picks up 60 percent of the total iodine in mother and child.

Education

By July 1 of this year almost $600 million in Federal funds had been spent or obligated under the National Defense Education Act since its passage in 1958, according to figures from the Office of Education. During this time—

• About 350,000 undergraduate and graduate students borrowed some $225

million to help finance their education, of which $202 million was in Federal money. Five times the amount due on June 1, 1962, had already been repaid — a total of $5 million.

• $150 million—matched by a similar amount in State funds—went to elementary and secondary schools for strengthening instruction in science, mathematics, and modern languages; and $2.7 million to private secondary schools for the same purpose.

• $17.8 million went to school counseling and guidance testing services. Local schools are now employing nearly 22,000 full-time guidance personnel, as compared with 12,000 before passage of the act.

• $22.4 million were expended on special institutes to train personnel for professional careers in counseling and in guidance—attended by more than 11,000 persons.

• $38.6 million went to fellows and graduate schools participating in a program designed to train college teachers.

Other expenditures were made for the development of language teachers and encouragement of the study of modern languages, the training of technicians—both youth and adults—for jobs related to the national defense, research in the use of audiovisual teaching equipment, and the spread into the schools of information developed by research.

School Desegregation

How did Atlanta and Memphis desegregate their schools so smoothly and why did Little Rock and New Orleans have so much trouble?

In a recent survey of school authorities in 30 city and county school districts in 9 Southern States, conducted by the Potomac Institute, a nonprofit organization in Washington, D.C., 30 out of the 34 persons interviewed said that they would find useful the answers to this and other questions concerning the steps to successful desegregation.

The survey was undertaken to determine whether school officials (superintendents and school board chairmen), "caught in a cross current between Federal law and State resistance," want aid in solving problems of school desegregation and, if so, what kind and from whom. Of the 30 school systems, 6 already had begun desegregation, 1 was under court order to do so, 2 had cases pending in Federal court, and 21 had not yet moved toward desegregation.

Such information, the majority of the respondents said, should come from a reliable education agency and should consist of "unbiased data," not "hints or suggestions."

More than half the interviewees (56 percent) said they could make use of consultants on desegregation, and 20 (59 percent) said they thought conferences dealing with problems of school desegregation would be of value. Reporting on the survey in "School Desegregation—Help Needed?" a publication of the institute, J. Kenneth Morland asserts that all the respondents—even those in districts where no desegregation has taken place—seem resolved to accept some desegregation in order to maintain public education.

TV and Children

A series of conferences to outline research projects on the impact of television on children will be held this fall under the auspices of the Department of Health, Education, and Welfare. Educators, child welfare specialists, research workers in the field of mass communications, and representatives of the television industry are expected to participate. In addition to recommending specific research projects—of scholarly merit as well as of practical use to television programers—the conferences will plan ways of conducting this research. Among the proposed research will be projects to assist the television industry to develop techniques for use in children's programs.

A seven-member steering committee, representing the fields of child welfare, education, and television, under the chairmanship of Bernard Russell, Acting Special Assistant to the Secretary of Health, Education, and Welfare, will direct the conferences. The committee, which met first in July, will, in addition to planning the conferences, recommend research projects on the basis of the conferences' proposals, attempt to arrange financial support, and set up an appropriate mechanism for their supervision. According to the chairman, since the responsibility for determining the content of programing lies with the broadcasters, the committee does not intend to interfere with that responsibility.

The Foundation for Character Education and the Ford Foundation are contributing conference funds and services; research sponsorship or financing may come from a number of different organizations.

Smoking

The wishes of the parents have little effect upon whether or not teenagers smoke, according to a survey of 1,414 high school students conducted in Levittown, N.Y., under the supervision of the Nassau division of the American Cancer Society. The survey was conducted in two high schools by two health teachers, Emanuel Plesent and Robert Waters, under the supervision of Anthony J. Di Benedetto, supervisor of health education and recreation. The students, who answered the questions anonymously, ranged from 14 to 19 years of age.

Their answers showed that 41 percent of the teenage smokers began to smoke despite the fact that they were refused parental permission, while only 8 percent of the nonsmokers cited parental disapproval as a reason for not smoking. Sixty-nine percent of the smokers, however, reported that they had been able to win parental permission a year or more after they had begun smoking.

The survey indicated that less than one-third of the students in the two schools are smokers (32 percent), and that a higher percentage of boys (36 percent) smoke than girls (24 percent). It also showed that most smokers (78 percent) began smoking regularly before they were 15 years old. The largest number reported they began smoking at 14, while 22 percent reported that they had started smoking regularly before they were 13.

The large majority of the smokers (62 percent) gave "relaxation" as their reason for smoking, while others cited "habit" (20 percent) and "social" reasons (15 percent). The nonsmokers gave the following reasons for not smoking: "health" (50 percent), "financial" (17 percent), and "social reasons" (17 percent).

An awareness of the harmful effects of smoking was indicated by a large number of both the nonsmokers (85 percent) and the smokers (50 percent).

The survey showed no conclusive difference between smokers and nonsmokers regarding participation in after-school or community activities, but it did show that the two groups do not

tend to mix socially. Among the nonsmokers, 85 percent reported that "some, few, or none" of their friends smoked, while a majority of the smokers (59 percent) reported that "all or most" of their friends smoked.

No discernible relationship to parental smoking habits and those of the teenagers showed up in this study, a finding contrary to the results of a study made in Portland, Oreg., in 1959 which found the most important factor distinguishing "high smoking" from "low smoking" groups of students to be whether or not the parents or older siblings smoked. (See "Modifying Smoking Habits in High School Students," by Daniel Horn, CHILDREN, March–April 1960.) In the Levittown study, 79 percent of both smokers and nonsmokers reported that one or both parents smoked.

. . .

The Public Health Service is setting up a panel of advisers to study the evidence from research on the impact of smoking on health, to evaluate this evidence, and make appropriate recommendations. The group will be selected by the Surgeon General after consultation with representatives of interested Federal agencies, professional groups, health organizations, and the tobacco industry.

Health Research

A national conference on research methodology and potential in community health and preventive medicine will be held in New York City, December 5–7, under the sponsorship of the Council on Research of the American College of Preventive Medicine and the New York Academy of Sciences. Cooperating organizations are the Children's Bureau, the Public Health Service, the American Public Health Association, the Aerospace Medical Association, the Armed Forces Epidemiological Board, the Industrial Medical Association, the American Academy of Occupational Medicine, the Association of State and Territorial Health Officers, and the American Association of Public Health Physicians.

Designed for community health agencies, the conference will emphasize methodology rather than the findings of studies, with major attention given to research in chronic disease, mental health, and accidents; evaluation of programs; operational research; and the development of a research climate. Illustrative studies will be drawn from local and State health department experiences as well as from industry and aerospace medicine.

. . .

A clinical research center in which premature infants will be studied for clues to basic biochemical physiological processes of human growth is soon to be established at the Stanford University Medical Center. The research, which will focus on a unit of six bassinets, is financed by a grant of $267,305 from the National Institutes of Health. This was 1 of the 10 grants made by the Institutes in June under a program begun in 1960 in which awards are made to medical schools and research hospitals for setting up centers of general clinical research on man and his diseases. The Stanford project is the first in this program to concentrate on problems of diseases in premature babies.

Another grant of the same series gave $285,000 to the Children's Hospital of Pittsburgh for initiating a clinical research center focusing on children's diseases.

. . .

The development of a method that has pinpointed the cause of one form of thrombocytopenic purpura, occurring in newborn infants, was announced recently by the National Institute of Arthritis and Metabolic Diseases, Public Health Service. This serious blood disease, comparable in some ways to that arising from the Rh factor in red blood cells, is uncommon and therefore is rarely recognized. It is characterized by bleeding caused by a lack of blood platelets—elements in the blood which prevent leakage of blood through the vessel walls.

According to the Institute, investigations have confirmed the long-suspected fact that most cases of infant purpura are due to antibodies formed in the expectant mother against a different type of platelet in the unborn child, whose platelet type is inherited from the father. The mother's antibodies are transmitted to the infant through the placenta, destroying his platelets and thus causing bleeding. The Institute's scientists noted that platelet mismatching can also occur in blood transfusions.

The new technique, for platelet-antibody detection, is based on complement fixation, a complex process involving measurement of the substance in blood called complement, which attaches to combinations of antigen and antibody, reflecting the degree of antigen-antibody reaction.

. . .

A California study of almost 5 years' duration that has been focusing on maternal deaths occurring within 90 days after termination of pregnancy has found that more than 100 out of 515 deaths reviewed thus far were attributable to abortion, and that of these at least 70 percent were criminally or self-induced. Maternal deaths reported from all causes totaled 725 during the period of the study, which is being conducted by the State medical association and public health department.

Other preliminary findings were that almost two-thirds of the women who died as a result of abortion were married; 15 percent had never married; the rest were widowed, separated, divorced, or with marital status unknown. Almost 30 percent had had five or more pregnancies and less than 15 percent had never before been pregnant. Almost half were 30 years of age or older.

The State department of public health is planning to publish in the near future a detailed report on abortion deaths.

Personnel

A substantial untapped resource to help meet the shortage of fully trained social workers may exist among social workers who are outside of the labor force because of family responsibilities, according to findings of research carried out by nine students of the Howard University School of Social Work.

The study, which was completed in the spring, examined some of the practices, policies, attitudes, and experiences of private social agencies in hiring and employing married female social workers with minor children. The investigators gathered and analyzed responses to questionnaires from some 300 private social agencies—affiliates of the Family Service Association of America and the Child Welfare League of America—in 45 States.

The findings revealed almost unanimous agreement among the agencies that the child care plan made by the mother was a major factor in determining whether or not she would be hired. Many social agencies reported that they considered social workers

who are mothers of small children to be valuable workers, but a significant minority expressed the opinion that the part-time status and family responsibilities reduced their effectiveness. In regard to the adaptation of personnel policies and practices to facilitate employment of such social workers, by allowing them to work less than a full day, at irregular hours, or less than a full week, the majority of the agencies expressed a preference for the last arrangement.

There was also more readiness to limit rather than to eliminate night and weekend work for these employees, the demand for this kind of work appearing to be greater the larger the agency.

Nutrition Program

On the basis of studies of the nutritional status of children seen in its health programs, the American Joint Distribution Committee, a voluntary agency operating health and welfare programs in Jewish communities in 27 countries including Morocco, Tunisia, and Iran, has broadened its efforts to improve the nutrition of children in these three countries. In addition to nutrition education efforts in health centers, schools, and community development projects, the program includes five forms of supplementary feeding. These are:

1. The distribution of milk for newborns and infants, supplied in various reconstituted forms through a series of milk stations.

2. The distribution to expectant or lactating mothers of food parcels designed to provide a satisfactory intake of protein, iron, and vitamins.

3. The provision to preschool and school children of at least one hot meal a day, through school canteens. These meals are designed for various age groups of children to provide two-thirds of their caloric requirements and, as nearly as possible, their total requirements of animal protein, calcium, and vitamins.

4. Distribution to families of food parcels designed to supplement their protein and fat intake.

5. Soup kitchens and communal canteens for destitute persons.

Some 63,000 people are receiving food through this program at a yearly operating cost to the Joint Distribution Committee of $600,000. Important in the program, the agency reports, are the surplus commodities donated by the U.S. Department of Agriculture. At present the agency is studying the ways of using fish flour, possibly on a 4-percent basis in a mixture for bread, as an inexpensive, easily transportable source of protein.

The program is supervised by four nutritionists in the field and three physicians and a nutrition consultant at the agency's European headquarters in Geneva.

Among the studies which influenced the nature of the program was one which compared the weight and dietary patterns of Iranian-Jewish infants with those of a group of infants studied in England and Wales. The study showed that at birth the weights of the two groups of children were similar, the British babies being on the average only 0.5 of a kilogram heavier, but after 2 years the British children were on the average 2.9 kilograms heavier than the Iranian children.

Health Services

The creation of a National Commission on Community Health Services, to conduct a 4-year study of community health needs and services, was announced in May by the cosponsors, the American Public Health Association and the National Health Council. During the first 2 years, the commission will supervise a number of local and national studies of health services.

The community studies will be carried out in selected areas under local leadership from the fields of health, education, and welfare, industry and business, and representatives of the public. Each community will study its own health problems, following prepared study guides, questionnaires, and consultation provided by the commission. Study content will include health problems, program resources, trends, use of knowledge, and attitudes toward health and health services.

The national study will involve task forces of three to five specialists each, which will prepare reports on assigned subjects, using materials brought together by the staff.

The activities of the commission will culminate in a national conference to discuss prepared reports based on the community study reports and task force reports. The conference will make recommendations for implementation within the following 2 years.

The program will be financed chiefly by philanthropic foundations, particularly the Kellogg Foundation, and by the Public Health Service.

Aid to the Unemployed

Only 15 of the 50 States participated in the Federal program of aid to dependent children of unemployed parents in the first year of its operation. These were Connecticut, Delaware, Hawaii, Illinois, Maryland, Massachusetts, New York, North Carolina, Oklahoma, Oregon, Pennsylvania, Rhode Island, Utah, Washington, and West Virginia.

Three out of every five applicants approved for aid in the program in the first 10 months of its operation were not receiving any help from local general assistance programs, and in two-thirds of the approved cases the unemployed fathers had no claims pending for unemployment compensation, according to an analysis made by the Bureau of Family Services of statistics from 14 of the States. In 47 percent of the cases the unemployed fathers were either ineligible for compensation or had exhausted their benefits more than 6 months before their applications for aid.

During the first 10 months of the program there were 123,987 applicants for aid under the program, with 93,547 approved for assistance; 36,660 cases were closed, two-thirds of them when the father returned to work. Only 2 percent were closed because the parent refused to accept offered employment.

Vital Statistics

Live births in 1961 numbered 4,282,000, which results in a birth rate slightly below the 1960 and 1959 rates, according to provisional statistics released in April by the Public Health Service. The relative stability of the birth rate, according to the Service, is likely to continue for a few years until the girls born in the bumper baby crops of 1946 and succeeding years reach childbearing age. Currently, the fertility rate is fairly steady at about 120 live births per 1,000 women in the childbearing ages.

The 1961 provisional infant mortality rate of 25.3 deaths under 1 year of age per 1,000 live births sets a new low record, the previous low occurring in 1960 with a rate of 25.7.

IN THE JOURNALS

Paternal Deprivation

Nineteen cases of children diagnosed in a pediatric clinic as suffering from a disturbance in the father-son relationship are reported in the July 1962 issue of *Pediatrics*. ("Paternal Deprivation—A Disturbance in Fathering," by Morris Green and Patricia Beall, pediatrician and social worker in the Department of Pediatrics, Indiana University School of Medicine.) The authors report that the patients, all boys between the ages of 4–15, presented a variety of behavior symptoms, including under-achievement in school, nervousness, fearfulness, depression, excessive daydreaming, and effeminate behavior, and such physical symptoms as obesity, headaches, ulcerative colitis, recurrent vomiting, tics, and enuresis.

On the basis of interviews with the father, mother, and child, the clinic found the fathers could be characterized in one of five ways: (1) the father who is unable to give emotionally to his child; (2) the father who does not know how to relate to a growing boy; (3) the noncommunicative father who is merely a "spectator" in the home; (4) the "married bachelor" still tied to his own mother's apron strings; and (5) the father who is disappointed in his son.

In most instances, the authors report, the mother tended unconsciously to encourage the father's aloofness.

The clinic in every instance stressed the importance of seeing the father and in all but five cases succeeded in this. Case management included a series of interviews with the child and his parents conducted by the pediatric resident and the medical social worker—except in those instances in which referral was made to appropriate facilities for intensive psychotherapy. The goal was to bring the father closer to the child—spatially and psychologically—and this was achieved to an appreciable degree in 11 cases, the authors report.

Cases in which the disturbed relationship arose chiefly from an imbalance in the interdependent roles of mothers and fathers achieved the most dramatic responses, according to the authors; while cases characterized by psychological immaturity of one or both parents responded poorly to treatment.

Planning for Children

In an article in the July 1962 issue of the quarterly, *Social Work*, Alfred J. Kahn, professor at the New York School of Social Work, calls on experienced practitioners and administrators to consider a number of "child welfare planning hypotheses" to attack "an urban child care crisis of considerable size" in the United States today. ("The Social Scene and the Planning of Services for Children.") Pointing out that life in the modern city creates "high-hazard groups," the author presents social trend data and evidence from a variety of child welfare studies to support his contention that the protection of children in our cities today requires:

- A much larger "institutional or developmental" emphasis in child care, including the provision of such services as day care, home help, family life education, and vocational counseling.
- Early evaluation and planning in individual cases involving family and child problems in a context organized to avoid the bias of the precommitted practitioner or agency.
- The availability in the community of a full range of services for maintaining minimum health and living standards and to protect family life, underpinned by a comprehensive and adequate public social service system.
- Overall coordination of functions and programs of service agencies and, in the specific case, integration of service and intervention.
- The establishment of mechanisms for accountability for competent planning and followthrough in individual cases where there has been community intervention.

"It means little," maintains the author, "to develop qualified foster home placement or residential treatment centers in communities which lack basic assistance programs and the related family casework or child welfare services to children in their own homes."

Foster Parents Are People

With the majority of children coming into foster care today as a result of family breakdown, the purpose of foster placement is to provide a therapeutic and rehabilitative experience for child and parent, say Nina Beck Tegethoff and Harriet Goldstein in the June 1962 issue of *Child Welfare*. ("A Realistic Appraisal of Homefinding.") At the same time, they point out, the availability of couples who can live up to the social worker's image of ideal foster parents is increasingly limited because foster parents "live in the same world as all parents" and are subject to the same pressures and anxieties as everyone else today. This means, say the authors, that child placement agencies must learn to use selectively as foster parents couples who, despite their weaknesses, have strengths as individuals and as a family unit which can be beneficial to particular children.

Maintaining that the risks of placement away from home must, like surgery, sometimes be undertaken to remedy a serious situation, the authors assert that the agency must be ready to invest in the treatment of child, parents, and foster parents; and that in respect to foster parents the investment must be to regard them as "semiprofessionals" to be stimulated by programs of on-the-job training and by financial compensation for service in addition to maintenance costs.

The authors also maintain that agencies should be ready to supplement their foster family resources with other kinds of settings for meeting children's needs, including agency-sponsored group homes, residences, or institutions.

The authors are, respectively, former casework supervisor and present group home specialist at the Association for Jewish Children, Philadelphia.

The Subtle Impact of TV

The conclusion that standards of good taste and judgment for television shows watched by children need to be applied at points of program origin, because of factors interfering with

parents' ability and motivation in this area, was drawn from a study of the views of 99 Chicago mothers on the influence that television has on their children. Described in the quarterly *Child Development* for June 1962 ("Parents' Views of the Effect of Television on Their Children," by Robert D. Hess and Harriet Goldman) by two members of the Committee of Human Development of the University of Chicago, the study indicated that these mothers were generally not concerned about the cumulative effects of television. They reportedly believed that television can have both good and bad effects—can keep the child quiet but can promote passivity—and that the networks and stations have "basic standards of good intentions toward the child viewer."

Though the mothers almost unanimously expressed the belief that parents responsibly supervise their children's TV viewing, the majority actually made little effort to give this supervision, according to the investigators, yet saw themselves as the most competent authorities for evaluating program content. The findings showed no difference in social class, except in the tendency to maintain that the content was supervised. Acknowledging the difficulty of measuring the subtle, gradual impact of television on children, the authors suggest that there is need for a public concept of television as a source of mediocrity which "hinders the full development of the child's mental and emotional faculties." They also suggest that schools and churches play a greater role in evaluating program content.

Maternity Care

Child and Family for July 1962 describes the difficulties encountered at St. Mary's Hospital in Evansville, Ind., after the introduction of a "family-centered" maternity care program and how these were overcome. ("An Obstetrician's View of Family-Centered Maternity Care," by Edgar L. Engel.) The chief aspect of this program is in giving the care of the baby to the mother from birth by leaving the baby by her bedside rather than in a nursery for newborns. When the program was first introduced, visiting was restricted to the father only, who could visit at any time of the day and was even welcome in the delivery room.

According to the author, who is head of the hospital's department of obstetrics and gynecology, the maternity division's census of patients unexpectedly declined in the months following the introduction of the program, but this trend was reversed after standard hospital visiting privileges were extended to the division—the infants being removed to nurseries when visitors were present. At the same time the hospital placed renewed emphasis on an educational program for personnel and the public as to the advantages of the program. These advantages are identified by the author as:

- An apparent decrease in the spread of infectious diseases brought into the maternity ward.
- More immediate attention to the infant's individual needs.
- The stimulation of a natural mother-offspring relationship.
- Increased opportunity for the mother to learn how to care for her baby while in the hospital.
- Activity of the father in supporting the mother in labor, resulting in a sharp reduction in the mother's need for analgesia and anesthesia, and an earlier acquaintance of the father with his child.

The article first appeared in the *Hospital Progress* series issued by the Hospital Association, St. Louis, Mo.

Battered Children

Describing the "battered-child syndrome" in the July 7, 1962, issue of the *Journal of the American Medical Association*, a pediatrician, a psychiatrist, an obstetrician, and a radiologist point to the importance of complete skeletal X-rays of every child presenting insufficiently explained injuries in order to determine whether there are evidences of past repetitive trauma and thus of deliberate child abuse. ("The Battered-Child Syndrome," by C. Henry Kempe, Frederic N. Silverman, Brandt F. Steele, William Droegemueller, and Henry K. Silver.)

The authors report that in a survey of 71 hospitals across the country, they found that 302 such cases had been identified during one year and that 33 of the children had died and 85 suffered permanent brain injury.

The battered-child syndrome is seen among children of all ages, report the authors, but most commonly among children under 3. Beating of children, they assert, is not confined to adults of psychopathic personality or of borderline socioeconomic status, though in all abusive parents there is a "defect in character structure which allows aggressive impulses to be expressed too freely" and in many "some suggestion that the attacking parent was subjected to similar abuse in childhood."

Pointing out that physicians have great difficulty in believing that parents would attack their children and in questioning them about it, the authors maintain that physicians are nevertheless responsible for initiating a complete investigation when symptoms of abuse are evident. Both physicians and hospitals have an obligation to report such cases to the police department or a special children's protective service, they assert, maintaining that a battered child should not be returned from the hospital to his own home even if the risk of repeated assault is only moderate.

Bad or Sick?

To ask whether a juvenile delinquent is "sick" or "bad" signifies the kind of "schizophrenic thinking" that blocks understanding and treatment of the delinquent, according to an article in the April issue of *Social Work* ("Juvenile Delinquents: Sick or Bad," by Seymour L. Halleck.) By very definition, states the author, the delinquent's behavior is bad. Delinquents are "sick," he adds, only if sickness is not conceived of as the result of external factors acting upon a passive individual, but rather as a personal vulnerability to stress.

To treat delinquents as not responsible for their behavior, the author asserts, is to encourage passivity and inadequacy. But to become engrossed in the "meaningless" concept of bad *versus* sick, he maintains, ignores the most important element in treatment—recognition of "the complex interplay of many causative factors" behind the delinquent behavior. His recommendation for an effective attack on delinquency is to try not only to modify the etiological factors in the external environment but to treat the "festering sores" of personality distortions within the individual—and avoid preoccupation with "badness, responsibility, or sickness."

The author is chief of psychiatric services in the Division of Corrections of the Wisconsin State Department of Public Welfare.

READERS' EXCHANGE

LOVATT: *Autistic children*

Margaret Lovatt's article, "Autistic Children in a Day Nursery," in the May–June 1962 issue of CHILDREN, is an excellent report of a venturesome service to the preschool schizophrenic child with autism. There is for me a personal gratification in learning of any new application of concepts which have been identified with the part of my work which was concerned with study of, and planning for, just such children. Many of my experimental approaches were, and often continue to be viewed as so controversial, that there has not been sufficient and varied testing over a period of time in different localities.

The Toronto experience described by Miss Lovatt might serve as a model for a program for the study and care of autistic schizophrenic children, who traditionally have been so unresponsive and therefore so frustrating to psychiatrists, psychotherapists, teachers, and parents who have tried to reach them.

No dramatic successes are claimed in Miss Lovatt's article, but there is a calm assumption that 2 years of the program with children who started at the age of 3 or 4 years would result in their placement in kindergarten or in the first or second grade with normal children. There is a healthy absence of any note of despair or demand for unending singleminded dedication of therapists and parents to the sick child without regard for the other normal demands of life and society. Instead, there is the emphasis on new or different approaches to meet the needs of the child, the family, and the service.

The realistic and truly experimental approach described by Miss Lovatt would seem to be the best safeguard against mutual rejection between autistic children and the therapeutic program, or between the parents of autistic children and the program.

An experimental approach must also be taken in working with the parents of these children and should be regarded, as it was in this program, as an integral part of the whole program with the ever-present recognition of the aim: to help parents face realistically the limitations, problems, and opportunities for their deviant child in terms of the present, including the chance to enjoy their childhood, and of the future, whatever it may bring, and not in terms of the parents' past failures.

Lauretta Bender, M.D.
Director of Psychiatric Research, Children's Unit, Creedmoor State Hospital, Queens Village, N.Y.

JOHNSON: *Nursing sick children*

As Dorothy Johnson indicates in her timely article, "Professional Education for Pediatric Nursing" [CHILDREN, July–August 1962], the quality of nursing care of children will be distinctly better in hospital units where the charge nurse is a well-prepared specialist whose main concern is patient care rather than an administrator who spends her time at a desk overwhelmed by paperwork. Such a nurse will know each child and each family. She will be able to interpret individual needs to all levels of personnel in the unit. She will be able to coordinate and promote the care provided by doctors, therapists, and members of other related disciplines. She will be secure enough to support the parents during periods of crisis.

Nurses have only begun to offer this kind of comprehensive care to sick children, not because of lack of interest, but because of inadequate understanding of what being ill means to a child. The impact of illness on an infant or child is quite different than it is on an adult, primarily because the child's growth needs make him more vulnerable to added stress. His reaction is more violent because his defenses are poorly developed. He needs help from meaningful adults, specifically his parents, in order to cope with the experience satisfactorily. If he does not get this help, the unresolved experience may leave him more vulnerable to other stresses of life.

A child's illness is a terrifying experience to his parents. They too need support—to be able to stay with the sick child, to understand the changes in behavior which illness brings, and to be able to verbalize their anxieties about their own child as well as other children they see in the hospital.

Florence Erickson
Professor of Pediatric Nursing, School of Nursing, University of Pittsburgh.

FRONTISPIECE: *Childhood's wonder*

I was so impressed by the frontispiece of the May–June 1962 issue of CHILDREN [see cut below], I couldn't help writing this sonnet:

"REGARD AND WONDER"
(Habakkuk 1:5)

A people sat in darkness, saw great light;
This boy: four years of silence, hears great sound.
Who felt the greater ecstasy, delight
At joys undreamed of and now newly found?
No Roentgen, Bell, Marconi ever knew
More rapture, wonder, as the once unknown
Became the known under his hand and view.
In this bright instant four dark years have flown.
A de profundis! Out of the depths, come! come!
A-boom! a-boom! trembles through hand and ears,
As Jim, his deaf friend beats upon that drum,
And with responsive palm his friend Sue "hears."
Don't pity these whose world's so deeply still:
They too know childhood's wonder and its thrill.

Park J. White, M.D.
St. Louis, Mo.

U.S. GOVERNMENT PRINTING OFFICE:1962

SOME U.S. GOVERNMENT PUBLICATIONS FOR PROFESSIONAL WORKERS

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IT'S YOUR CHILDREN'S BUREAU: the Bureau's current program. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. CB Publication No. 357 revised. 1962. 62 pp. 25 cents.

An entirely new edition of this publication tells the story of the Bureau's work to advance the well-being of children through its own services or through those of other agencies, public and voluntary. It describes the kinds of activities the Bureau engages in directly, or fosters in the States, and the categories of children served.

FIVE DECADES OF ACTION FOR CHILDREN: a history of the Children's Bureau. Dorothy E. Bradbury. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. CB Publication No. 358. Revised 1962. 143 pp. 55 cents.

Starting with an account of events that led to the creation of the Children's Bureau in 1912, the booklet tells the story, enriched with selected illustrative quotations, of the Bureau's 50 years of activity. The history is divided into seven periods: the early years (1912–21), the years of economic crisis (1921–33), the years when the Social Security Act's maternal and child welfare program (1934–40) got underway, the wartime years (1940–45), the postwar decade, and the years from 1957–62. It concludes with a statement looking to the future by Katherine B. Oettinger, the Bureau's present Chief.

CASEWORK SERVICES IN PUBLIC ASSISTANCE MEDICAL CARE. Sarah A. Butts. Department of Health, Education, and Welfare, Social Security Administration, Bureau of Family Services. 1962. 110 pp. 50 cents.

Directed to public assistance caseworkers, this publication discusses the needs of public assistance recipients who are physically ill and the caseworkers' responsibilities in helping them to utilize medical care provisions offered by the State and community.

RESEARCH RELATING TO JUVENILE DELINQUENTS. No. 2 of a series, Research Relating to Special Groups of Children. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. 1962. 100 pp. 35 cents.

A total of 477 research projects on juvenile delinquency reported to the Children's Bureau Clearinghouse for Research in Child Life since 1948 are listed in this publication together with pertinent data reflecting the main trends in each research area.

SERVICES IN PUBLIC AND VOLUNTARY CHILD WELFARE PROGRAMS. Helen R. Jeter. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. CB Publication No. 396. 1962. 126 pp. 40 cents.

A compilation of data on services to about 389,000 children in 42 States—approximately 74 percent of the estimated total number of children served in this country by State and local, public and voluntary child welfare agencies and institutions that report annually through State public agencies to the Children's Bureau. Collected through a new reporting system initiated in 1960 that records each child once on one day of the year, regardless of the number of agencies or institutions serving him.

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AN INTERDISCIPLINARY JOURNAL FOR THE PROFESSIONS SERVING CHILDREN

Programs for Juvenile Offenders

Care of Disturbed Children

Understanding Foster Parents

Use of Case Conferences


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AN INTERDISCIPLINARY JOURNAL FOR THE PROFESSIONS SERVING CHILDREN

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MASTERING A SKILL. The greatly increased incidence in Europe of deformities among babies whose mothers had taken the drug thalidomide during pregnancy has accelerated interest in further research in prosthetics in relation to children. This 3-year-old, who was born before the appearance of thalidomide but whose impairments are similar to those produced by the drug, eventually will have a prosthesis for his left arm similar to the one which he is learning to use effectively for his right arm.

A member of the bar with a master's degree in social work from Western Reserve University, William H. Sheridan has been with the Children's Bureau since 1949 when he came as consultant on juvenile delinquency. When the Division of Juvenile Delinquency Service was created in 1954, he became Chief of its Technical Aid Branch, moving from there to his present post in 1960. Before coming to the Bureau, he was chief probation officer with the Juvenile Court in Cleveland.

Until recently part of the evaluation team at the center which they describe in this issue, Thomas Atkins (right) is now chief psychologist at the Philadelphia Child Guidance Clinic, and psychiatrist Ora Smith is director of the Oakbourne Hospital in West Chester, Pa., a residential treatment center for children. Dr. Rose is director of the Philadelphia Child Guidance Clinic.

This fall Jacqueline McCoy has returned to her alma mater, the George Warren Brown School of Social Work, Washington University, to work for her doctorate. Since her graduation from there 11 years ago, she has concentrated on foster family and adoptive home finding for the past 7 years with the City of St. Louis Department of Welfare.

Besides providing the psychiatric consultation at the Tyler-Smith County Health Department, as described here, Loyce Buie (right) practices psychiatry privately in Tyler, Tex. Thelma Saba's 11 years in public health nursing included direction of an inservice education program at a State hospital and before that a national leisure-time program for children. With 32 years of private medical practice, Jesse Goldfeder assumed his current post in 1958.

A graduate of the New York School of Social Work, Hannah Oppenheimer began her social work career as a child welfare worker in Alleghany County, N.Y., later serving as child welfare supervisor in the public welfare department in Oswego County in the same State. Two years ago, she joined the staff at the Huntington Family Center, where she gives therapy to families with many problems.

Since 1948, Milton J. E. Senn has been with Yale University, where for several years he has headed both the Department of Pediatrics of the Medical School and the Child Study Center. He specialized both in pediatrics and in psychiatry after taking his medical training at the University of Wisconsin. While a member of the pediatric staff of Cornell University Medical School, he became a Commonwealth fellow.

◀ *the authors*

GAPS IN STATE PROGRAMS FOR JUVENILE OFFENDERS

WILLIAM H. SHERIDAN
Assistant Director, Division of Juvenile Delinquency Service, Children's Bureau

WITH THE ADVENT of the juvenile court movement 60 years ago, a new legal process was created for the handling of child offenders. It was based upon a philosophy of treatment, of rehabilitation rather than punishment. Some lawyers refer to it as the doctrine of *parens patriae*. Others regard it as a method of providing individualized justice, requiring the following:

1. A judge and a staff identified with and capable of carrying out a nonpunitive and individualized service.
2. Sufficient facilities available in the court and the community to insure—
   (*a*) that the dispositions of the court are based on the best available knowledge of the needs of the child.
   (*b*) that the child, if he needs care and treatment, receives these through facilities adapted to his needs and from persons properly qualified and empowered to give them.
   (*c*) that the community receives adequate protection.
3. Procedures that are designed to insure that two objectives are kept constantly in mind, these being—
   (*a*) the individualization of the child and his situation; and
   (*b*) the protection of the legal and constitutional rights of both parents and child.[1]

During the last decade, the procedures and practices of juvenile courts have been under critical scrutiny. This interest has been reflected in appellate court decisions and in various law review notes and articles, as well as in the 1959 revision of the "Standard Juvenile Court Act"[2] and "Procedure and Evidence in the Juvenile Court."[3] This has been a constructive experience for the juvenile courts and has pointed the way to changes which should enhance their effectiveness and status throughout the country. In many courts, changes have already been made which have brought closer one objective of individualized justice: more adequate protection of the legal and constitutional rights of parents and child.

Legal protection, however, is only one of two elements of individualized justice. The second is equally important: protection of the child and the community through individualizing the child in treatment. This requires the provision of services and facilities adapted to various needs, staffed by persons qualified to use present knowledge of the behavioral sciences in the child's behalf.

It is about time we took a hard look at the second element of individualized justice by scrutinizing State and local programs available to the courts for the care and treatment of delinquent children. Adequate local probation services are vital to juvenile courts. However, probably as many as half of the courts have no such services. Even where probation services exist, high caseloads and lack of trained workers often negate their effectiveness. However, progress in improving these services, although slow, is being made with the support of local citizen and professional groups.

Unfortunately, this local interest generally does not extend to State programs. The old adage "out of sight—out of mind" applies in many States to the child who is placed in State care. This lack of interest seems as typical of professional persons who work with juvenile offenders in local communities as it is of the general public. For example, a list of 145 suggestions for workshop discussion at a recent meeting of a national organization composed of such persons contained only 6 topics concerned with State programs.

Yet the children in State care eventually return to local communities—some too soon because of the overcrowding in State institutions, some having

learned more about delinquency because of the poor institutional programs. Moreover, for a variety of reasons, many local communities increasingly must turn to the State for certain needed services, such as detention care and residential clinical facilities. The spread of metropolitan areas far beyond local political boundaries, the rapid expansion of our population, and its great mobility, all exert an increasing pressure upon our already inadequate programs, and indicate an urgent need to develop strong State programs to underpin local efforts.

For the most part, State programs for the care of delinquent children are still limited to the institutional care provided by State training schools. With few exceptions, the "treatment" programs in these schools go little beyond meeting needs for the care of children away from their own homes, some not even this far. This condition exists in spite of the sincere efforts of conscientious staff in many training schools. Some of the reasons can be found in factors beyond their control which pose almost insurmountable problems.

Training Schools

Most public training schools for delinquent children are "catch-all" facilities faced with the care of a heterogeneous population. The only common factor applying to all of the children in them is that each has committed an act, whether defined as delinquent or not, which has brought him under the jurisdiction of the juvenile court.

These young people range in age from 8 to 18 or 19, and occasionally even to 21; in intelligence, from the retarded to the superior; in experience, from the naive child who has only incidentally committed a delinquent act to repeaters with confirmed, sophisticated delinquent patterns; in personality, from the withdrawn to the highly aggressive, acting-out delinquent; and in treatment potential, from the youngster who wants help and can use it profitably to the one who rejects all help. The individuals in each of these groupings all have different potentialities and problems. Some of these children present programming difficulties because of physical handicaps or pregnancy. To adequately meet the program needs of each child in such a diverse population is not possible within a single institution.

Complicating the situation further is the problem of overcrowding. Four out of ten public training schools are caring for populations which exceed their stated capacity.[4] Because of overcrowding many schools return children to their homes prematurely in order to make way for committed children who are awaiting placement.

Expanding present facilities, however, is not the answer to overcrowding. Many of the institutions are now too large, and specialists in group care, who have recommended a maximum capacity of 150, have pointed out that, unless their size can be limited, the therapeutic atmosphere and program necessary for individualized treatment cannot be maintained.[5] The fact that the returnee rate is considerably higher among larger institutions than among smaller ones seems to support this.[4] Ways and means need to be found to limit training school populations to a size appropriate for treatment and to children more homogeneous in their treatment needs. A first step in this direction is to review the selection process.

Primary Selection

Since, under our constitutional government, rights cannot be denied without due process of law, the primary intake control for State care, which in most States is the training school, rests in the judicial branch of government, specifically in the juvenile and family courts. The gross criteria at this point are age and the commission or omission of an act, the nature of which places the child under the jurisdiction of the court.

Even these criteria vary from State to State and sometimes within States, since the upper age jurisdiction of these courts varies from 16 to 21. It is 18 in about two-thirds of the States. In some States where the upper age jurisdiction of the juvenile court is 18, the court can not only commit a youngster up to this age, but even youngsters over 18 whose delinquent acts were committed before reaching that age. Since, in most States, court orders vesting legal custody may continue in force until the child reaches majority, the upper age of the school populations, theoretically at least, can be 21.

Although the age criterion is the roughest of guides and has little value as a selective factor for the institutional population, the law needs some readily ascertainable objective standard to confer jurisdiction in the courts. Age, therefore, is a necessary gross criterion at this time for a program of handling juvenile offenders, as it relates to court jurisdiction.

A finding that the child has committed a delinquent act or has failed to do something he is required to do is also a primary prerequisite in establishing the jurisdiction of the court. The nature of the child's act is also an important factor in determining whether State care is required in order to protect

the child or the community, but in this respect it should not be the controlling factor but only one of many others which need to be examined by social and clinical study of the child. However, none of the factors which indicate whether State care is called for should necessarily be controlling as to the nature of the care needed. While such factors may be of help in determining this, other factors are equally important.

Procedures for Refinement

The use of certain procedures can be steps toward the refinement of the process in which primary selection is made.

Social and emotional maturity are not achieved at any given chronological age. Whatever age is specified as the upper limit of juvenile court jurisdiction causes problems. There are always some youngsters below this age limit who, because of their personality and degree of maladjustment, cannot, even with the advances that have been made in treatment knowledge and techniques, profit from present programs designed for the treatment of adolescents. Because of this, many State statutes provide for flexibility through the waiver power which permits the court discretion in exercising jurisdiction. This, under certain conditions, gives the juvenile courts the option to retain jurisdiction or to transfer the child to a criminal court.

While the power to waive in cases involving felonies was incorporated in the first Standard Juvenile Court Act (sec. 12),[6] as well as in the latest revision (sec. 13),[2] the Children's Bureau had recommended a more flexible provision to the committee preparing the latest revision of this model statute. Under this proposal, the courts could also waive jurisdiction over older youth—18 to 21—for offenses less than felonies as well as jurisdiction over children over 16 who are already under the care of an agency or institution if it can be shown they were not responsive to treatment. In order to prevent abuses of the waiver process, the provision would require that additional specific findings be made prior to waiver.

Use of such a waiver provision would weed out the older aggressive, acting-out delinquents who need continuing care in secure custody—in most States probably a relatively small number of the juvenile offenders. Effective use of the waiver would, in a large measure, be determined by the adequacy of the court staff.

Another provision in the 1959 Standard Juvenile Court Act (subdivision 2, sec. 21) prohibits the commitment of children who have come under the court's jurisdiction because of neglect or conduct which would not be criminal if committed by an adult, to institutions established primarily for children who commit acts which would be crimes if committed by adults. Such a provision might help to refine the selection process; but in many instances it could be circumvented by changing the allegation from "incorrigibility" to specific law violations which often have been part of the behavior leading to an incorrigibility petition.

Questionable Methods

Some of the legal provisions resorted to in order to control training school populations are subject to question. For example, a number of States have established, either by statute or executive order,[7] minimum ages of 10 to 12 for children who can be committed to the State training schools. As previously pointed out, any attempt to use age as an absolute control is highly questionable. Also questionable is the assumption that all delinquent children under 10 or 12 do not need institutional care. When there is no facility available for delinquent children other than the State training school and a child is in need of group care outside of his home, such a provision may have the effect of denying the child care and treatment. In any event, the type of foster care best suited for the individual child should be established by careful social and clinical study.

In spite of the waiver provisions in their statutes governing juvenile courts, a number of States are bypassing the judicial process through the practice of transferring youngsters from an institution for juvenile delinquents to a penal institution for persons convicted under criminal procedures. This far too common practice has been unchallenged until recent years. A study of 139 public institutions made several years ago indicated that 40 percent had the authority by legislation or executive order to transfer their charges to penal institutions.[8]

This practice is unsound both legally and socially. Not only does it deny the transferred youngster, who thus becomes a "prisoner," the protection of criminal proceedings, including a jury trial, but it also undermines the philosophy of the whole juvenile court movement, which was established primarily to protect the child from contacts with adult criminals and from being stigmatized as a convict. Recently there have been several court decisions forbidding such transfers;[9] others have upheld the practice.[10]

Both the 1959 revision of the Standard Juvenile Court Act[2] and the new Standard Family Court Act[11, 12] provide that "An institution to which a child is committed . . . shall not transfer custody of the child to an institution for correction of adult offenders."

The laws of a few States permit the juvenile court to commit a child directly to an adult penal institution on a finding of delinquency. While this practice is as unsound as the practice of transferring a child to such an institution, it was recently upheld in Ohio where the court of appeals was reversed after granting a writ of *habeas corpus*.[13]

The American Psychiatric Association has suggested that children be admitted to training schools on a voluntary basis by agreement with parents.[14] This proposal has not gained any degree of acceptance among social workers or judges.[15] Many factors argue against such a proposal. Parents are often ambivalent and, since the agreement could be terminated at any time, would in many instances fail to leave their child in the institution long enough for treatment to be effective. Many communities are without diagnostic services to determine the child's need for such care, and there is always danger that undue influence or coercion will be used in either placement or release. It cannot be presumed that parents are always acting in the best interest of the child nor that the public interest will always be considered. More than an agreement seems necessary to protect the rights and interests of both the public and the child. Moreover, effective program planning and coordination require a more consistent formalized procedure.

These arguments do not imply that service and care for a delinquent child, either under State or local auspices, should never be available except under court commitment. Certain types of care or service might be provided by agreement with parents, such as casework services in situations involving child-parent conflict, or residential diagnostic study. However, generally continuing care in the State program for delinquent children should be provided only through court commitment.

The court's role as the *primary* intake source for State services and care is necessary since only through court action can the legal custody of a child be changed. Many courts, however, are not able to discharge this primary responsibility adequately because they do not have the necessary auxiliary probation and clinical services.

Even with such services available to the court locally, there is great need for a *secondary* screening mechanism. This is true for several reasons. Such a mechanism could be helpful in meeting the problem of diversity in training school populations. It could compensate for defects in the selection process due to inadequacies in local services. And, increasingly important, it could make for efficient administration and effective coordination within the State program as the States diversify and expand their facilities and services for delinquent children.

Custody to State Agency

A secondary screening mechanism can be established through a change in the commitment process, making it possible to commit the child not to a specific facility but to the department of the State government responsible for the administration of the State's program for the care and treatment of delinquent children, often referred to as the "parent agency." Provided for in the Standard Juvenile Court Act[2] and the Standard Family Court Act,[11] such a procedure has in fact already been in effect for some years in several States—California, Delaware, Idaho, Illinois, Massachusetts, Minnesota, Texas, Washington, and Virginia. In other States it will require changes in the structure of the executive branch of State government, particularly in States where the responsibility for administering the State's program for the care and treatment of delinquent children is divided between two or more agencies or boards.

The vesting of legal custody in a specific State agency is most important from the standpoint of individualized treatment. As pointed out earlier, the specific nature of the treatment or care needed by a child is not necessarily determined by an adjudication of delinquency. Nor do the child's treatment needs remain fixed or constant; they shift and change as the child develops during care and responds to the treatment he is receiving. Therefore, a variety of facilities or services are required not only for determining changing needs but also for meeting them. These are not determinations which can be made by courts unfamiliar with the day-to-day treatment needs of the child and which may be several hundred miles away from the child after commitment. They can best be made by representatives of an agency having legal custody for the child, who are knowledgeable about the services and facilities which it has at its disposal, and who are aware of the child's changing needs.

Some juvenile courts have questioned this type of

commitment procedure as well as the granting of authority to the State agency to make certain treatment determinations. However, as long as the right to due process is preserved through judicial action, these practices do not impinge on the constitutional function of the judicial branch of government.

The Supreme Court of Illinois has held that "The determination of where the criminals shall be placed or committed is wholly within the legislative authority; and except as the legislation has conferred, the courts have no discretion in the matter."[16] In the same decision, the court said, "Provisions of the Youth Commission Act under which the Commission may place youths committed to it under indeterminate sentences in appropriate institutions, order their release or parole, or discharge such persons from custody, do not involve an unlawful delegation of judicial power to an administrative agency. . . ."

The administrative agency, however, should not be given carte blanche. Its authority should be limited to the powers of a legal custodian, the parent or guardian and the court retaining those powers deemed appropriate.[1] Procedural safeguards governing the operation of the agency should be established,[12] and provision made for court review upon request of child, parent, or guardian of certain major treatment determinations of the agency.[2]

The law should require the parent agency to accept legal custody of the child and to provide care and treatment when the kind needed is consistent with the agency's responsibilities.[1,12] In the interest of the public and the child, the agency should not be permitted to "close intake."[17] No minimum age limitation on commitment should be imposed since this could have the effect of denying the child necessary care or the community protection.

Under this type of commitment, the intake of each specific facility would be controlled by the parent agency. Thus the initial placement and, if indicated, later transfer of the child to another type of facility for children could be based upon the individual child's needs and available resources. Children who, after study, are found not to need treatment in foster care could be returned home under supervision. It should not be necessary, however, for all children to be routinely processed through a reception and diagnostic center. Some courts have fairly adequate probation staff and clinical services. When the study and diagnosis presented to the court are adequate and reflect the need for a specific type of care, the court might well recommend the specific facility. This recommendation could be reviewed by the State agency, possibly by its field staff, and arrangements made to send the youngster directly to the agreed upon facility.

Comprehensive Programs

In the absence of a variety of treatment resources, a secondary screening mechanism can serve little if any purpose. Therefore, action to secure such a mechanism needs to be complemented by action to develop a statewide program of diversified services and facilities for the care and treatment of delinquent children and youth. Ideally, in addition to training schools, which might be set up on a coeducational basis, such a program should include diagnostic study centers, detention facilities, small residential treatment centers for seriously disturbed children, facilities for the care of defective delinquents, forestry camps, foster family homes, and group homes. Casework services should be available to delinquent children whether in or out of their own homes.

Such a diversified program can help meet the problem of overcrowding and permit the establishment of more homogeneous treatment groupings of delinquent children. It can help attain the second goal of individualized justice by assuring for all delinquent children the individualized care and help they need to develop maturely.

There is ample evidence of the failure to develop such programs. For example, many training schools have youngsters who need the kind of training provided in a facility for the mentally retarded, but who cannot be sent to the State schools for the retarded because of their long waiting lists. The same is often true of the emotionally disturbed or prepsychotic youngsters who need treatment in a hospital or other specialized facility. In the State institution for delinquents not only are mentally defective or sick children not getting the specialized training or treatment they need, but they add to the difficulties of operating a therapeutic and educational program for others.

The heterogeneous populations in training schools also reflect the disparity in local services. It is not uncommon to find children in training schools who could have remained in their own homes had adequate probation or other treatment services been available in the community.

While many large urban areas have been able to develop local institutions and other intermediate types of care and service for delinquent children presenting less serious problems, smaller commun-

ities in rural areas have had to depend upon the State institutions for care for all of their delinquent youngsters. As a result, the young people coming from large urban areas are more likely to be older and more sophisticated in their delinquency pattern than those coming from small communities in rural areas. Protecting the younger, more malleable youngster from the influence of the more hardened delinquent is an institutional problem of no small proportions.[18]

A State agency into whose care delinquent children are committed needs to work not only for the diversification of its resources for treatment and care but also for the development and improvement of local community services. One way it can help is through the provision of technical assistance and of training programs for personnel.

In a State program for child offenders, structure and procedures alone, regardless of how sound, will not achieve the goals of individualized justice. Strong, alert, professional leadership is a must. The support of the executive and legislative branches of government as well as that of all citizens—professional and lay alike—is equally vital. For, without effective leadership and adequate financial support, the goals of individualized justice for children cannot be attained.

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[1] U.S. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau: Standards for specialized courts dealing with children. CB Publication No. 346. 1954.

[2] Committee on the Standard Juvenile Court Act of the National Probation and Parole Association (now National Council on Crime and Delinquency) in cooperation with the National Council of Juvenile Court Judges and the U.S. Children's Bureau: Standard juvenile court act. *National Probation and Parole Association Journal,* July 1959.

[3] Advisory Council of Judges of the National Council on Crime and Delinquency: Procedure and evidence in the juvenile court. New York. 1962.

[4] U.S. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau: Statistics on public institutions for delinquent children. CB Statistical Series No. 59. 1958.

[5] ———: Institutions serving delinquent children: guides and goals. CB Publication No. 360. 1957.

[6] National Probation and Parole Association (now National Council on Crime and Delinquency): Standard juvenile court act. New York. 1927.

[7] U.S. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau: Some facts about public training schools for juvenile delinquents. CB Statistical Series No. 33. 1956.

[8] Rowland, Robert L.: Public institutions for delinquent children, 1956. U.S. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. CB Statistical Series No. 48. 1958. (Out of print.)

[9] *State ex rel. McGilton* v. *Adams,* 102 S.E. 2d 145 (W. Va. 1958); *White* v. *Reid* (D.D.C. 1954), 125 F. Supp. 647, 126 F. Supp. 867; *Stinnet* v. *Hegstrom* (D.C. Comm. 1959), 178 F. Supp. 17; *Cogdell* v. *Reid* (D.D.C. 1954), 183 F. Supp. 103; *Knutter* v. *Reid* (D.D.C. 1960), 183 F. Supp. 352.

[10] *Merton* v. *Heyden,* 142 A. 2d 37 (Maine 1958); *Sonnenberg* v. *Markley,* 289 F. 2d 126; *Clay* v. *Reid* (D.D.C. 1959), 173 F. Supp. 667, 272 F. 2d 527.

[11] Committee on the Standard Family Court Act of the National Probation and Parole Association (now National Council on Crime and Delinquency) in cooperation with the National Council of Juvenile Court Judges and the U.S. Children's Bureau: Standard family court act. *National Probation and Parole Association Journal,* April 1959.

[12] U.S. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau: Proposals for drafting principles and suggested language for legislation on public child welfare and youth services. 1957. (Multilithed.)

[13] *In re Darnell,* 173 O.S. 335 (1962).

[14] Ad Hoc Committee of the American Psychiatric Association: Training schools for delinquent children. American Psychiatric Association, Washington, D.C. 1952. (Out of print.)

[15] U.S. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau: Report on the national conference on juvenile delinquency, June 1954, Washington, D.C. 1954.

[16] *People* v. *Fowler,* 151 N.E. 2d 324 (Ill. 1958.).

[17] *State ex rel. Schwartz* v. *Haines,* 179 N.E. 2d 46 (Ohio 1962).

[18] Grosser, George H.: The role of informal inmate groups in change of values. *Children,* January–February 1958.

Every community, urban and non-urban, has as much delinquency, as much social pathology as it deserves. If dependency rates are higher in our urban cities, if delinquency rates are shocking, it is basically because our urban communities have not learned what we are teaching the people of underdeveloped countries—that social planning and development, the provision of preventive and rehabilitative social services, must accompany planning and development on the economic front.

James R. Dumpson, New York City Commissioner of Welfare, to the 1961 meeting of the American Public Health Association.

"Whose crisis?" asked the staff of an evaluation center after they reviewed referrals for . . .

EMERGENCY CARE OF DISTURBED CHILDREN

THOMAS E. ATKINS
Formerly, Chief Psychologist

JOHN A. ROSE, M.D.
Consultant

ORA R. SMITH, M.D.
Formerly, Director

Eastern Diagnostic and Evaluation Center, Philadelphia

AMONG the many problems facing services for children, none is more critical than the necessity to operate from crisis to crisis. Under such circumstances the long-term needs of the child and the real nature of the crisis may be overlooked. Although the extent of the child's disturbance and past instances of failure of services in dealing with it may be clear, situational pressures compound past errors and the result is frequently a referral for emergency institutionalization. When this occurs, the receiving institution often is intended not as a treatment resource, but as a convenient custodial center for containing children whose behavior has become disturbing to the community. Most mental hospitals have among their population a sizable number of children who have been "dumped" in this manner, without adequate preliminary study or planing for their return to the community.

In order to permit more selective use of the limited institutional settings available to emotionally disturbed and defective children in the Philadelphia area, the Pennsylvania Department of Public Welfare has established the Eastern Diagnostic and Evaluation Center, an outpatient service for children, without direct access to inpatient beds. Located in the city, the center serves an area having a population of about 3½ million persons. It accepts referrals only from professional sources and only when other community resources are inappropriate. A basic intent of the center is to function collaboratively with State, community, and private health, educational, and welfare facilities in dealing with complex, or chronic, diagnostic or dispositional problems. Because of the center's screening function, most referrals to it have constituted a "last ditch" effort on the part of the community to cope with a severely disturbed child or situation.

The community in which the center is located is probably typical of most large metropolitan areas in having a comprehensive network of social agencies which provides a wide range of services for children and their families. These services include many hospitals and clinics offering medical care or psychiatric treatment on an outpatient basis, but few facilities suitable for inpatient psychiatric care of children. There is a modern facility for the short-term detention of children in trouble with the law, which unwillingly finds itself providing care to children with varying degrees of mental retardation or emotional disturbance. Several child-care facilities which offer residential care and casework service on a long-term basis, with psychiatric consultation are also available, but they serve only a select group of children whose degree of disturbance is not so pronounced as to prohibit attendance at public schools nor to require maximum supervision and control.

Based on a paper presented at the 1962 annual meeting of the American Orthopsychiatric Association.

Because of the number of emotionally disturbed children in the community, the severity of their problems, and the inadequacy of services for them, the center has received many so-called emergency referrals in which the request is for immediate admission to a State hospital or a State school for the retarded. The child is always described as severely disturbed, the family as more or less disintegrating, and the community as "up in arms." Invariably, these referrals have in common a note of urgency bordering on panic.

In each instance, an emergency clearly exists. However, we have found that these emergencies seem to be as characteristic of the problems of services—both numerically and qualitatively—as they are of the extent and nature of the child's disturbance.

Source of Emergencies

Our experience indicates that psychiatric emergencies in children are the culmination of a complex interaction of forces in which the child's disturbance plays an important but not usually a primary role. We have found that emergencies are of several types, each of which presents unique problems in immediate management and subsequent study and disposition. There are cases of acutely disturbed children in which the immediate need is for clarification of the caretaking situation, location of parents, and mobilization of resources or individuals in the community. There are other cases in which the child's behavior warrants immediate therapeutic intervention. Other emergencies result from acute family or community breakdown, which in addition to introducing stress with which the child is unable to cope, constitutes a critical problem in community service responsibilities. In many of these so-called "pressure" cases, the degree of disturbance in the child, while not primary, is sufficiently critical to warrant immediate study. Still other cases become emergent only after diagnostic study is begun.

All emergency cases, however, appear to have in common an enduring and pervasive disturbance in the child which has been the focus of past ineffective planning on the part of the family and of services. There is a common history of expedient solution to past crises, which have broken down and increased the child's disturbance as panic spreads through the surrounding matrix of personal and professional supports. Each case thus presents an individual problem of evaluating the absolute needs of child and family after factors of secondary distortion have been allowed for.

The nature of childhood dependency is such that evaluation of the emotionally disordered child must include evaluation not only of the family caretaker but also of the constellation of services involved with family and child. We have found that the dumping of children into institutions is abetted by services which on one day view behavioral aberration in a child as a minor problem in social adjustment, and on the next as a major psychiatric disorder.

Emergency Cases

In a 13-month period, during which approximately 550 cases became active with the center, 42 were identified as "emergency." We have analyzed these through data obtained from a standardized intake information form, a semistructured initial contact interview, other case material, and correspondence. Our analysis reveals few features which differentiate these cases from nonemergency cases, other than the fact that the disturbed child is interacting with the community services in a way that requires immediate, decisive intervention in order to maintain some semblance of equilibrium, for child and community.

The 42 children in these emergency cases included 22 boys and 20 girls. Their ages range from 5 to 18, only six being younger than 11. Of these, four were boys between 5 and 8; two were girls of 9 and 10. There were three times as many white as nonwhite boys. Among the girls, the proportion of white and nonwhite is in the opposite direction: two to three. Of the total group, roughly half of the children were in the 13- to 15-year age range.

Twenty-nine of the 42 children were living in their own homes at the time of referral. Four children were in foster family homes or living with relatives. Nine were either hospitalized or institutionalized in settings which were no longer considered appropriate.

In school, 20 of the children were in grades normal for their age. Four were one to three grades behind their age-grade expectation. Seventeen were in special classes or excluded from school. Only one was a preschool child.

The overwhelming number of these children could be described as situationally deprived and dependent. Almost two-thirds came from families with incomes less than $4,000 per year. More than a third were from families supported primarily by public assistance grants or Government pensions.

Registrations with the Social Service Exchange indicated that the families of three-fourths of these children were known previously to social agencies.

One-quarter of the families had more than five registrations, which means that they had been through the intake department of one or more agencies at least six times. One family had 38 registrations.

Forty-seven percent of the referrals for emergency service came primarily from medical sources; 5 from family physicians, and 15 from hospitals or outpatient clinics. Approximately 25 percent came from private psychiatrists (7) or mental health clinics (3). Of the remaining 25 percent, five came from the local public agency serving dependent children and three each from other social agencies and the schools. Among the symptoms reported by the referral source, the most common was aggressive behavior—listed in approximately one-half of the cases. Bizarre behavior was only slightly less common. Suicidal or homicidal threats were reported in only one-sixth of the cases. Sexual acting out as a prominent symptom was mentioned in only five of the referrals. In about half the cases, the child was a severe problem to the school, was involved with the court, or was the focus of complaint from the community because of aggressive behavior toward peers and younger children.

Only 2 of the 42 children had received psychiatric treatment prior to the crisis and in these cases the treatment had been received within 2 years of the time of present referral. In five other cases psychiatric treatment has been sought but not persisted in. In about half the cases, there had been medical or psychiatric consultation or attempt at treatment just before the referral of the case to the center. In most of the latter, medication had been prescribed and in a few instances the child had been receiving a tranquilizer or sedative for several weeks prior to the referral. In only a small number of these children had medication ameliorated the behavior.

A review of the case records of the 42 children indicates that in nearly every instance the child's disturbance was a chronic and pervasive one, preceding the current crises by several years. In the majority of cases, there had been an indication of a disturbed maternal-child interaction in infancy; in at least three cases, for example, the mother had considered criminal abortion early in pregnancy.

The typical picture in the families of these children was one of extreme family instability, currently and in the past. This was reflected in the many contacts these families had had with welfare agencies, some of them dating back as far as 25 years. Severe marital conflict was described in most cases, and a history of mental illness in one of the marital partners was an equally frequent finding. The behavior of parents in the emergency situation reflected this instability; it was not unusual to note disorganized behavior of near-psychotic proportions in one or both parents. In only two cases did it appear that there was a reasonably stable family situation.

In a number of instances, there was, at the time of referral, overt conflict between different child welfare services with respect to responsibility for the child's custody.

Interviews and Disposition

The nature of an outpatient psychiatric service geared to handling such emergencies is dictated by community pressures and understanding, the existence of other services, and the availability of staff time. Our service, therefore, should be regarded as an evolutionary attempt to cope with a specific pattern of need in a particular community. It might differ in another community or under other circumstances. In developing it, we needed to consider both the immediate and long-range needs of child, family, and community, within the context of the limited facilities for children with severe emotional disorders.

Our professional team includes the disciplines of child psychiatry, pediatrics, clinical psychology, and psychiatric social work. Special laboratory, neurological, and medical consultation services are available as needed. Team members participate flexibly in response to the needs of the case. In any specific case all variations of child, parent-child, family-child, and sibling-child interviews may be held with one or more professionals and with a timing that is individual in every case. Each interview has structure and focus, but these may be altered in an interview by professional communications on the case.

We have found that certain areas must be covered in interviews and examinations in order to assess the nature and degree of the crisis. Viewing each crisis as resulting from a multiproblemed interactional disturbance between the child, the family, and the community, we initially attempt to obtain a comprehensive overview of the situation. We do this through the use of a semistructured interview that systematically samples the adaptive behavior of the child and caretakers, currently and over the course of the child's development. We also learn what we can of the past experience of the mother, especially in relation to her methods of coping. Also included in this exploratory interview is a consideration of the

ways the members of the family receive emotional and social support, and the demonstrated capacities of the child and family to utilize support from others.

In our contacts with the child, we make every effort to evaluate his present disturbance in relation to his age and developmental stage, his endowment, and his past interaction with the environment. During this process, brief therapeutically oriented intervention is carried out in relation to presented symptoms such as attention getting, excessive demands, and control of others. For example, rage reactions and other uncontrolled behavior may be dealt with by protectively holding and comforting the child. Medications are stopped which depress consciousness and confuse integrative functions and evaluation of transactions between self and others. There is a studied attempt throughout to restore a more normal interactional pattern to child and family by decreasing elements of panic.

Simultaneous with our attempts to obtain a comprehensive view of the child in his family, we also try to find out about the relation of the present crisis to the community. Thus we routinely collaborate with other agencies who have serviced the family, including the school, and the court if it is involved. We also communicate with the family physician both to obtain information and to determine whether he is a possible source of support to the family. Usually, a preliminary alert is given to possible facilities for emergency admission.

When it is clear that the situation is, in fact, too much for the child and his support system, we recommend hospitalization for him, telling both the child and his parents. When hospitalization is not regarded as immediately necessary, additional contacts with the child and family are scheduled—sometimes on a daily basis—in order to obtain perspective in regard to immediate and long-range goals. In either event, direct and frequent communications about the developments in the case are furnished to the likely inpatient service.

The 42 emergency referrals had a variety of dispositional outcomes. Immediate hospitalization was recommended and effected for 10 of the children. In each instance, the child was hospitalized in a facility planned for adults—a sad commentary on the adequacy of community facilities. In 27 out of the 42 cases, there was time to hold more than the initial interviews with the child and family. In six of these cases, admission to institutions was arranged within 5 days to 2 weeks. Five of the six children were hospitalized in an adult setting; one was placed in a State school for the mentally retarded. In five other cases, the brief psychotherapeutic contact with the center proved adequate for meeting the crisis, so that the child could be referred for service to more appropriate community services or the family could continue to manage without further appointments. So far as is known, the children in these cases were not subsequently hospitalized, at least for the specific condition for which they were referred to us.

Half the cases (21) proceeded into a complete diagnostic study in the center extending from 1 to 8 months before disposition. In three of these cases, the children were eventually admitted to an adult State hospital setting, which was considered appropriate, though not ideal, for their needs. Six of the 21 children with diagnostic studies were placed in a children's setting in a State hospital; 4 were sent to State schools for the mentally retarded; 2 children were admitted to psychiatric wards in community general hospitals because of acute exacerbation of symptoms during the course of the evaluation. On the recommendation of the center, two children were committed to correctional schools by the court, one child registered at a psychiatric outpatient clinic, and one was placed in a foster family home and one in a group residence. One child was continuing through complete diagnostic evaluation by the center, with the contacts geared to providing specific supports to the family during the management crisis.

In a few of the cases, the nature of the Evaluation Center's contacts with family and child seems to have introduced a level of stability into their functioning which, when coupled with more adequate use of community resources, seems to have resulted in long-range amelioration of the disturbance. In most cases, however (31 out of 42), complying with the initial request for hospitalization was the only sound solution. However, in these cases, the psychotherapeutic intervention of the center made possible the use of the inpatient setting together with sustained community contact with the child and family.

Creation of Emergencies

The psychodynamic value of the center's service seems not to rest entirely upon the availability of psychiatric beds for children, but rather upon consideration of the individual case needs in order to provide an organizational experience for family and child. The view taken by the professional staff is that constructive disposition of a case is not possible until the family's capacity to cope with problems

had been evaluated and their perceived social supports enhanced. For example:

The center was asked to evaluate the case of a 15-year-old boy who had been referred directly to a State hospital because of his behavior in a local detention home. He had been considered a behavior problem in school for several years, and a year ago had been suspended because of sexual misbehavior and deteriorating schoolwork. At about the same time, he had been arrested for minor thefts and placed on probation with his parents. The family was described as "substandard," with a long history of contacts with various social agencies and the courts. The father was said to "appear to be mentally ill." Little hope was offered that the mother would participate in planning for the child.

When the mother was interviewed, after some difficulties in arranging an appointment, she said she was afraid her son would be put in a mental hospital with "older people who are violent and senile." She was accompanied by her husband who she said had suffered a serious head injury a year before which had left him with a severe memory disturbance and periods of extreme irritability and confusion. She told of frequent moves and longstanding economic deprivation which had only recently improved as a result of her employment. Her description of the interaction, with respect to this child, included extreme differences between herself and her husband in relation to the giving of affection, guidance, and discipline, with the boy caught in the middle. His current placement in the detention home was his first separation from the family.

Recognizing the many stresses operating on this mother, we were able through supportive therapeutic intervention to involve her actively in planning treatment for her son as a positive growth experience, rather than as an authoritarian decision that further emphasized her feelings of failure and frustration.

As this approach has been examined and developed, it has become clear to the staff that emergencies are less often created by radical changes in the state of the child and more by sudden alteration of the support from community services as perceived by the family. The groundwork for sudden changes in the support available to the family is laid when the initial evaluation made by a child welfare service is inadequate. When this has been so, common stresses such as a death in the family, moving, divorce, and economic catastrophe become the focus of radical changes in the agency's perception of the needs of the case, followed by sudden incapacity to support the family. Marginal caretaking situations then break down when agency support is withdrawn.

We also found that stress was often introduced unwittingly by a service acting on its own without knowledge of, or with little regard for, other services also involved. An unplanned change in foster placement, the rejection of the family by a service, the dismissal of the child from school, or the termination of some other plan for care or treatment were among the contingencies noted. For example:

After 5 years in a private school for the retarded, a 12-year-old girl was precipitously discharged to her family because of "destructive behavior." For a period of 2 months afterward, the parents frantically attempted to obtain assistance in her management or placement from physicians, influential persons, agencies, and the local school district. The mother, who had a history of periods of severe depression, was completely unable to cope with the child's voracious appetite, periodic hyperactivity, and excessive demands. At the time of referral, the mother was so "nervous and fed up" that she would "walk out of the home and let the child take over completely." The outpatient department of a local hospital and a private physician were unsuccessfully attempting to control the child's hyperactivity with medication and the provision of general support to the parents. The child's disruptive behavior was jeopardizing her participation in a local day-care program for retarded children, which had been arranged by the local school system. Urgent requests for institutionalization had been made indiscriminately to a variety of State institutions and to offices. A clear emergency obviously existed in terms of the child's behavior and the family's coping ability, as well as in the services that had been involved in attempting to provide interim services.

In our pattern of community health, education, and welfare services for children, each service too often seems to regard itself as independent of all others. We found that a change made by one service may set in motion a chain reaction whereby all services become overstressed and unable to be of help.

A review of our emergency cases indicates that our present dilemma derives from the culmination of past failures to recognize and cope with disturbances in children, in families, and in community services. These cases reflect the need for an examination of patterns of service in relation to needs of children. They show all too clearly the lack of a continuum of services suitable to a wide range of childhood problems and the tendency to view treatment and management as a dichotomous choice between inpatient and outpatient. They reveal the inevitable and predictable result of service patterns which make the child's disturbances conform to the available settings.

It seems unlikely that much can be accomplished immediately to change materially the factors contributing to emergencies. On the other hand, it seems quite possible to develop an individual service's capacity to cope with emergencies. The provision of support, immediate availability of service, and continuing contacts and communication among services are areas in which emergency situations reveal the most deficit. There seems to be a good deal of wishful thinking associated with emergencies that, instead of alleviating, may prolong and exaggerate them. A panic response on the part of a service to acute disturbance in a child may contribute immeasurably to its outcome. Our experience suggests that children and families in an emergency situation may have potential for coping that is not always recognized. It is, therefore, necessary to provide a comprehensive, professional approach that focuses attention on the needs of the child and family, and the capacities of his environmental supports; and one that consistently views immediate institutionalization as only one of several possible solutions to a crisis.

How foster parents can be helped to see the sharing aspects of their role through understanding . . .

THE MOTIVES AND CONFLICTS IN FOSTER PARENTHOOD

JACQUELINE McCOY
Homefinding Supervisor, Division of Children's Services
St. Louis Department of Welfare

IN RECENT MONTHS there has been a new focus in foster home supervision within the Division of Children's Services of the St. Louis Department of Welfare. This had its beginnings in the group meetings for foster parents.[1] While the participants conveyed a real interest in being foster parents and a desire to do their job well, they repeatedly expressed a confusion about their role in caring for a child within the agency structure. Consequently, an attempt was made to conceptualize the foster-parent role.[2] The result was a concept of the foster parent as a partial parent, playing an "as if" role toward a child for a temporary period of time, and at all times having a shared responsibility toward the child. The present article will deal with some implications of this concept for work with foster parents—especially foster mothers. The important role of the foster father will also be considered, though more briefly, for this is somewhat less well-defined.

Historically, and all too often in the present, foster parents have been looked on as caretakers of the children for whom the agency has responsibility. The foster home is thought of simply as a resource, a place to lodge the child. And this it is in a physical sense, but we cannot effectively use this resource if we do not understand the components within it. Foster parents are not just caretakers of children, they are individuals in their own right; individuals with needs, desires, feelings, attitudes, and values; individuals desirous and capable of giving to a child; individuals living within a family and a culture. Unless the caseworker has this concept of the foster parent—that of an individual enacting a role as one human being in relation to another—he will not use the resource correctly.

The foster mother is, then, an individual and the particular role that she is playing toward the child is that of a substitute parent. This is very different from being a caretaker, because the role of parent, or a substitute parent, brings with it many deeper considerations than just taking care of a child. In addition to giving food and lodging to the child, the foster mother will be giving of herself through love and emotional investment; she will be teaching the child values, attitudes, and patterns of behavior. In other words, she will be acting as a mother.

The foster mother actually plays another role within her status as foster parent, her role with the agency. In this context, also, she must not be thought of simply as a resource, but as an individual giving valuable service to an agency. This very definition of "foster parent within the structure of an agency" means that the care of the child is a responsibility shared between the foster parent and the agency. Thus, the foster mother is a member of a team whose

interest is the well-being, health, and growth of the child. She participates in this sharing through her work with the caseworker.

Part of this sharing with the agency involves the natural parents, a fact which also affects the foster mother's role with the child. She can never be a "real" or "only" mother of the child because the presence of the natural parents in fact or in the mind of the child makes this impossible. Thus, the foster mother not only shares the child with the agency but with the natural parents as well—not only in the present but also in the future.

Thus, the foster mother is a partial parent and possibly only that for a time. This makes her role one of the most difficult any individual can be asked to play and one that raises many questions. How can a foster mother invest emotionally in a child and have the investment come to naught when the child is moved? Why would she suffer the pain that comes with the loss of a child, an experience that is so frequently a part of foster parenthood? How can she be a mother and not a whole mother? How can she want and love a child and not have it belong to her? In order to answer these questions, we must consider some of the motivations that lead individuals to offer to board a child.

Foster Parents' Motives

Motivations that lead women to apply to become foster mothers are, at present, not well-defined, but we may assume that the most obvious and consistent of these is the applicant's desire for a child. Dorothy Hutchison, in her book, "In Quest of Foster Parents," points out that the applicant always asks for a "baby" in her request regardless of the age of the child she desires.[3] This means that she is asking to play the role of a mother toward the child, to love it, to have it belong to her, to take care of it, and to be needed by it. There is a strong need of possession in many of these requests which is often directly expressed. Applicants frequently make such statements as "I want a child I could treat and feel like one of my own," or "I want a child that I would love like my own," or "being a foster parent is the same as being an own parent, giving love and care," or "being a foster parent would be the same as being his own mother and father."

The important point here is that applicants for foster children make a request for a child within the frame of reference of natural parenthood which is often their only basis of experience in caring for children. This is consistent with the applicant's desire for a foster child as an expression of her need for a baby, another child she has produced herself; in other words, an expression of her fertility. Foster mothers express this desire repeatedly, not only at the time of application but also at the time of placement. Caseworkers often hear such expressions as "I love him like my own" or "I can't remember my life without him." A great part of this denial of the agency's and natural mother's role in the life of the child is based on the foster mother's need to feel that she has produced the child. The fantasy of having produced the child is often clearly revealed when the foster mother must be separated from him. Many foster mothers are rather successful in maintaining this fantasy and then react to separation as if it were death.

Take, for example, Mrs. D:

> Mrs. D applied for a baby to board when her own three children were older—one married and out of the home, the other two, teenagers. An infant was placed with her directly from the hospital on a preadoptive boarding basis. From the beginning, the caseworker warned her that the baby eventually would be placed for adoption, which would mean his permanent separation from her. The caseworker visited the foster home consistently at weekly intervals to share responsibility for medical planning with Mrs. D and try to make the role of the agency and her own role as a foster mother real to her. As time went on, however, it became evident in the way Mrs. D handled the baby and talked about him that she had made him her own.
>
> When the adoptive placement was finally made, Mrs. D found separation from the baby extremely hard to take and told the caseworker that she felt that he had died. She sobbed, grieved, and mourned as if she had, indeed, been faced with death. The caseworker spent considerable time with her, supported her, and as Mrs. D's grief subsided, talked about the meaning of foster parenthood—the pleasures of giving to a child as well as the pain of giving one up.

In asking for a foster child, the applicant is expressing many other needs and desires than her own need to have a child. Among the most positive of these is the desire to extend to others the satisfactory experience of mothering she gave to her own children. She may also need to mother a child of the opposite sex than her own child or children. Other motives may be less positive, sometimes stemming from a sense of failure with her own child—a desire for another chance to succeed as a mother, a desire to gain pleasure from a child which she did not receive from her own child or perhaps from anyone else in her life, an attempt to assuage guilt at not having more children of her own, or a means of giving her husband a child.

Some mothers may mask their emotional needs in their requests and ask for a child merely as a companion to their own child or as a means to make some "pin money." Others may conceive of themselves as a mother of all children, a "mother earth."

Whatever reasons the applicant for a child gives, the fact remains that she is asking to become a foster mother as an expression of her womanliness and of her desire to mother a child.

Mrs. S applied to the agency for a child to board when her own two daughters were 11 and 13. The reason she gave was that since she had enjoyed caring for her daughters and could not have any more children, she desired the experience of foster care. After she received her first foster child she began requesting more and more children, and as the agency has come to know her better, her true motivation has become increasingly evident.

Because of a physical condition Mrs. S had been told by her doctor not to have more children. She followed his advice although this was in conflict with her religious beliefs. She has used the foster parenthood experience, the taking care of other children as a means of alleviating her guilt and of proving to herself that she can produce and mother children that she feels were denied to her.

Understanding Mrs. S's motives, the agency has been able to help her see more clearly her role as a foster mother. Recognizing that she has a need to give to many children, the agency has used her home for children that need her kind of giving—a giving that is not too deep but nonetheless gives the child the security of being wanted.

The following is a good example of the "mother earth" type of foster mother:

Mrs. B requested foster children when her own 10 children were grown and, most of them, had left home. She had never questioned her capacity as a mother and had thoroughly enjoyed her experiences. Her expressed and underlying motivation in applying for a child was that she missed having small children around and believed she could give a good home to a foster child. Also, she said, children made her feel young. She has approached foster parenthood with the same unquestioning attitude—a child is a child and she can be his mother while she has him. In recognizing Mrs. B's faith in herself and her continuing desire to be a mother, the agency has been able to give many kinds of children the positive experience of living with her. Since she has no desire for a child of her own, she is able to give excellent care on a temporary or emergency basis.

These examples illustrate how the identification of the foster mother's motivation can help the agency to place her in a role which will suit both her desires and the needs of the agency. However, the underlying motivation for foster parenthood is often veiled during the study procedure, as in the case of Mrs. S, and only becomes clear as a child is placed and the experience is lived.

Role of Foster Father

The foster father's role is one of far less visibility to the caseworker. And yet the foster father is constantly in the picture, even though in a less direct way, as far as involvement with the agency is concerned.

To begin with, the foster father defines to a considerable extent the role of the foster mother. The reverse is, of course, equally true. This principle is further reinforced by the fact that foster parenthood is not only relevant in relation to the child but that in some very essential ways it is also a problem of marriage.

While few data exist to prove this, it is probably true that the activeness, or passivity, of the husband in relation to the foster child greatly influences the way in which the foster mother perceives of her role. Since the foster child was placed with the family, rather than conceived by it, he is a child who only tentatively belongs there not only for mothering but also for fathering, and this may be more evident to the father. Moreover, in natural child production, while the wife "gives" a child to her husband, the activation agent of the gift is the husband whose positive self-image is enhanced by his ability and need to be a father, to "support" his family not only in the breadwinning sense but also in the sexual sense. Bringing a foster child into the home whom the father has not helped to produce may profoundly affect his image of himself as a father and a husband.

It has been our experience that foster families tend to be matriarchies, in which the rearing of children and the decision-making regarding their welfare is considerably more in the hands of the wife than of the husband. But even in such families one may not assume as a matter of foregone conclusion that this always satisfies the husband. While he may not do much about this, and while psychologically he may need an aggressive wife, the arrival of the foster child may awaken some internal but dormant conflict. Societal censure, implicit or explicit, may tend to strengthen his image of himself as a dependent man. And this is reinforced by the fact that it is the foster mother who provides care to the child more than the father. Additionally, there always exists the danger that the "pact" between the agency and the foster mother may intensify the man's inner conflict over his masculinity. In the eyes of the passive husband, the agency may easily become the "ally" of the wife and be perceived as a further threat to his masculinity. The agency has substituted for the father in giving a child to the foster mother. The wife in effect shows her husband that she is able to "have" a child without him. What may follow unless carefully discussed with *both* parents is anger, frustration, and a sense in the father of being "bypassed" by the appeal to an outside source for a child.

The foster father's motivation in joining his wife in an application for a child is not always clear. Often he simply defines it as a desire to make his wife happy.

In recent years much has been written about children who remain for long periods of time in foster

homes, children whose parents contribute little or nothing to their physical or emotional lives, children who belong to no one. Much criticism has been leveled at child-placing agencies for allowing these children to grow up without a sense of identity, with little or no security. This criticism has stimulated agencies to relook at the children under their care and the reasons for their being there. Emphasis is now being placed on making a definite diagnosis of the child's family situation at the time of intake with frequent reevaluations as part of planning for permanent care, either back with the child's own family or in adoptive placement. Thus for most children needing care, the ideal foster placement is now considered to be a temporary placement.

As we have already mentioned, a foster mother's request for a child is an expression of her womanliness and desire to mother a child, with possession and belonging implicit in this desire. This wish to have the child belong to her is in direct contradiction to the impermanence and sharing implicit in foster care, and means that a conflict exists between what she envisions as her role as a foster parent and what the agency has in mind for her. At our agency, we try from the very outset of the application to help the foster mother face the question of how her image of her role fits in with the needs of the agency. Is what she wants the same thing the agency has in mind for the child? We help her see that we appreciate her need to express her femininity through parenthood—in fact, this is one of the capacities for parenthood that we look for—but that the other part of this, her desire to have the child belong to her, is directly at odds with the goals of the agency.

Foster-Home Supervision

The agency defines the foster mother's role as a mothering person present in the child's life for a defined length of time; a person who can give him sustenance and security and from whom he can eventually be separated without trauma. The foster mother is helped to see how to act with the agency on behalf of the child, to give to him in the present without thought of the future. She is helped to see that she cannot "possess" the child, that, in fact, the nature of the foster-home experience makes this impossible, and that she must share the responsibility and planning for him with the agency. We try to help her to shift her idea of being a mother to a particular child to the idea of mothering children through the services of the agency.

A daytime foster mother with the two children for whom she provides care while their mothers are at work. Substitute mothers in a day-care program need the same qualities of flexibility and motherliness as do full-time foster mothers.

The supervision and development of a foster home begins not with the placement of the first child, but with the first contacts the applicants have with the agency. This is the home finder, the caseworker who makes the home study.

In many agencies the educative function of the foster-home study is passed over with a few remarks about agency policies, supplemented by the presentation of a manual to the new foster parents. When this is all that is done, the worker has missed an opportunity, and often the only opportunity, to begin building with the foster parents a firm foundation for their future relationship with the agency.

Most people making application to board children have little knowledge of social work, child placement agencies, or foster children, let alone a realistic conception of the foster parents' role. The educational function of the foster-home study, therefore, lies in three primary areas. First, the caseworker is responsible for introducing the applicant and her family to social work and what it means to work with a social worker. Secondly, he is responsible for introducing the family to the functions, policies, and procedures of his agency and its place in the community. Thirdly, he is responsible for introducing the family to the foster-parent frame of reference with particular emphasis on the foster-parent role.

The period of the home study is the only time the foster couple is alone in a relationship with the case-

worker. Therefore, this is the ideal time, not only for evaluating the quality of their family life, but for helping the couple to begin to fit their attitudes, experiences, and frames of reference into their new role as foster parents. Of course, the desire for a child will still be primary in the applicants' minds, and it is questionable how completely they can assimilate the new interpretations until they have actually lived as foster parents. However, the home finder's efforts at interpretation will give them the advantage of a foundation of understanding when they receive their first foster child.

Mr. and Mrs. J applied to the agency for a small boy, age 4. During the initial group foster-home orientation meeting, they expressed understanding of the agency's need for families who could serve many children over a period of time, as this was explained to the group. By the time of their first individual interview with the home finder, they had already begun to think about the kinds of children they might take rather than the kind of child they wanted. They had shifted their thinking from "the child for them" to a child who would need them. Before the home study was completed, they had moved from their original concept of taking a little boy to "be like their own" to a willingness to accept any foster child between the ages of 2 and 8 who might need them.

A little girl, age 9, was placed with this family and they accepted her with warmth and understanding. About a year later she was returned to her mother and although it was very difficult for the foster parents to see her go, they understood what she had been saying to them in words and action—that she needed and wanted her mother. Since this first placement, Mr. and Mrs. J have accepted children from toddler age up to 10 years of age. Through their numerous experiences they have truly realized the concept of being foster parents to children.

All is not so ideal and agencies do make mistakes and compromises, as our agency did with Mrs. M.

Mrs. M requested a little girl about the age of her own daughter who was 7. The foster-home study showed that Mrs. M was a rather unhappy person, dissatisfied with many aspects of her life. She questioned her capacity to mother and found some dissatisfactions, as well as many satisfactions, in her own child. The positive factor was that she reached out for children and obviously enjoyed contact with them.

Mrs. M stuck to her request for a small girl, and eventually one, age 5, was placed with her. She immediately identified with this child and obviously found many satisfactions in her she had not found in her own child. Her words and actions implied that the child belonged to her alone and not to her husband. Trouble began when the natural parents entered the picture. In spite of the worker's efforts to interpret the inevitability of this and support the foster mother in a sharing role, she could not accept this and asked for the child to be removed.

Thus, apparently some people can move into the foster-parent role and others cannot. Sometimes the failures are due to misevaluation of the foster parent's potential for doing this, but sometimes they are due to the fact that the living of foster parenthood is difficult to conceptualize and anticipate on the part of the foster parent and caseworker alike. Some fruitful research has already been done in regard to ways of determining foster parenthood capacity,[4] but this is still an area in which we need more knowledge and understanding.

In the continuing supervision of foster homes, the caseworker works from the same concepts as already described.

When a child is offered to a family for the first time, the foster mother is faced with the prospect of putting into practice her new-found role and of experiencing in actual day-to-day living the conflicts of foster parenthood. She must be a substitute mother giving love, interest, care, investment of her self while sharing the child with others, knowing he can never be fully hers. The caseworker can best help her by recognizing her as a individual living with a conflict she can never completely resolve even with the caseworker's help, since the agency cannot give her the child she desires.

Caseworkers often feel that the first separation from a child makes or breaks a foster mother as a foster parent, as it did Mrs. M. All of our words do not and cannot do what a living experience can do. Often the only first separation can teach the foster mother the real meaning of the partial, temporary, and sharing aspects of foster parenthood.

However, caseworkers can make the job of foster parents—fathers as well as mothers—easier for them by understanding and helping them to handle their feelings in regard to their foster child and the limitations of foster parenthood.

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Our civilization is doomed if the unheard-of actions of our younger generations are allowed to continue. They are rowdy and disrespectful and they stay up late at night.

From an ancient tablet unearthed at an excavation site in Ur; quoted by Arthur Roth in The Teen-age Years, *Doubleday Co., 1960.*

In an attempt to strengthen staff use of mental health principles . . .

A PSYCHIATRIST PARTICIPATES IN A COUNTY HEALTH PROGRAM

LOYCE C. BUIE, M.D.
Psychiatric Consultant

JESSE GOLDFEDER, M.D.
Director

THELMA H. SABA
Nursing Supervisor

Tyler-Smith County Health Department, Tyler, Tex.

PROBLEMS associated with mental health and illness have long confronted the public health field without being recognized definitively as a major responsibility of public health agencies. However, since World War II local health departments have increasingly sought to determine their responsibility for maintaining mental health. Some departments have established mental health clinics or after-care services; others are seeking a way to add mental health dimensions to existing programs.[1,2] Among the latter is the Tyler-Smith County Health Department in Tyler, Tex.

Located in an urban-rural county of 86,000 inhabitants, this health department 2 years ago introduced psychiatric consultation in an effort to integrate mental health principles and methods into its program. The focus has been on the nursing services, but the project has also drawn in the local physicians participating in clinics and well-child conferences. Ultimately, its effects are expected to reach out to other areas of health department functioning.

In addition to the health department, Smith County's health and welfare services include a county child welfare unit, a local office of the State department of public welfare (categorical assistance), a one-worker county welfare department (general assistance), a juvenile probation department, and a mental health association with a full-time executive. There are also school counselors and visiting teachers, a vocational rehabilitation counselor, and four psychiatrists in private practice.

The health department includes on its staff 2 full-time doctors, 9 full-time nurses, and 17 part-time clinicians, as well as sanitarians and auxiliary personnel. Six of the nurses have had at least 6 months' specialized academic preparation beyond their R.N. training. The nursing staff renders a generalized nursing service to the entire county, including work in school health programs in rural schools, community immunization clinics, crippled children clinics, maternal and well-child conferences, and home visiting for direct nursing or followup of any of these programs.

The chief spark to the department's mental health project was the nurses' interest in learning how they might work better with their patients whose physical ills are so often complicated by emotional problems and difficulties in personal, family, and social adjustment. Therefore, its main emphasis has been on helping the public health nurses find answers to the many questions which were puzzling them. For example, how can the nurse "reach" the mother who says she wants to attend well-child conference sessions but repeatedly breaks appointments? Or, how can the nurse motivate parents unwilling to exercise their child's clubfoot, or to keep his splints on at night "because he cries"?

In staff discussions of the frustrations of their

jobs, the nurses had expressed a desire to improve their interviewing techniques and to learn to use anticipatory guidance in all phases of their nurse-patient relationship. These goals, it became clear, called for an inservice education program based on problems and situations arising in day-to-day public health nursing practice, and drawing on the special insights of a mental health professional to augment the resources of pediatricians, obstetricians, and other clinicians who staff the various clinics and conferences.

With this impetus, the local health department secured funds from the mental health division of the State department of health for the services of a local psychiatrist to set up and operate such a program. The State mental health division also provided periodic field consultation in the program's planning and developmental stages.

Rationale of the Project

Planning proceeded on the theory that increased understanding of the dynamics of behavior—including the interactions of the nurse-patient, nurse-doctor, and doctor-patient relationships—would enable the nursing staff to function more effectively; that this would be observable in strengthened rapport between the staff and patients and more acute awareness of patients' nonverbal communications; and in improved interviewing as well as more comprehensive service to the patient and his family. This increased effectiveness, it was believed, would be especially valuable in the maternal and well-child conferences for promoting improved emotional growth and development of children.

From the beginning, it was decided that the psychiatrist was *not* to give direct diagnostic or treatment services to patients, but was, rather, to act as consultant to the nursing and clinical staff. The essential purpose of her contributions would be to help the nurses and doctors do their own jobs more satisfactorily by the more telling use of their individual abilities and the practical application of psychiatric theory.

Presentation of formal theory was kept at a minimum, but psychiatric insights were brought into focus as situations arose to make them meaningful within the framework of normal nursing or clinical functioning. For example, the nurses could learn—without plunging into detailed psychoanalytic theory—that listening for the feelings attached to what a person is saying can make it possible to understand and facilitate the gratification of his unvoiced emotional needs. Occasional explanations of concepts were anticipated as necessary in order to put together observed pieces of present-day knowledge of child development, parent-child relationships, and patient-nurse-doctor interactions.

It was anticipated that the psychiatrist would meet with nurses individually and as a staff, and that she would observe and participate in clinic procedures and postclinic conferences with nurses and clinicians. Further planning for the use of her services was left flexible to accommodate needs.

Orientation

The psychiatrist spent her first month on the project observing the nurses' and clinicians' roles, responsibilities, and routines. She attended the clinics and visited homes with the nurses to reorient herself to the public health milieu and to get the "feel" of family patterns and problems in the health department's clientele. She also initiated six 1-hour seminars for the nursing staff—on emotional growth and development, and structure, ingredients, development and characteristics of personality.

These seminars were followed by a 2-day workshop on "Applying Mental Health Principles in Public Health Nursing." Participating with the psychiatrist as resource people in this stage-setting workshop were mental health and nursing consultants from the State department of health.

In helping to plan the workshop, the nurses identified goals directed toward personal growth and professional growth. The goals for personal growth included: a better understanding of how to work with people; more knowledge about why people react to situations as they do; and learning not to show personal reactions and feelings at inappropriate times. The professional goals identified were: learning to accept reality situations with objectivity, to give what help is possible and to increase it where needed, to improve interviewing skills, and to be more considerate of other people and their problems.

The objectives of the workshop were: (1) to encourage the nurses to substitute empathy for sympathy in work with patients; (2) to develop within the limits of public health nursing skills, improved handling of patients with emotional or mental problems; and (3) to provide the individual nurse with support and self-understanding when needed.

In the workshop the nurses presented case examples of mental health problems they had observed in their patients. These case presentations and the subsequent discussion revealed attitudes both of

overidealization and resistance to psychiatry as well as other more objective insights. Anticipation of criticism of their work apparently evoked in the nurses some feelings of insecurity and anxiety. However, when instead of criticism, they encountered understanding, acceptance, and support, they relaxed and offered their own observations and evaluations of cases more freely. At times the nurses expressed feelings of overwhelming helplessness and frustration in regard to the mental health problem under discussion. These expressions were met with discussion of the obstacles to ideal mental health services in the community and with encouragement to learn to accept feelings of frustration.

The workshop clearly revealed the need for greater objectivity on the part of nurses in handling patients and for increased skill in applying the mental health principles they already knew. There was evident, however, a unanimous desire to learn to work more effectively with patients, for everybody participated in the discussion and offered suggestions not only in regard to the handling of individual cases but also in formulating goals for the mental health program.

Thus during the first month of the program, the public health nurses, their nursing supervisor, the psychiatrist, and the outside consultants began to learn together some of the implications of a mental health approach to their professional roles as well as to agency functioning. The first awkwardness of the period when the program was on trial with the staff was quickly overcome.

On the Job

Following the orientation period, a schedule was devised to enable the psychiatric consultant to spend 17 hours a month working with nurses and clinicians. The schedule included: 6 hours in individual conferences with nurses about specific patients or problems in working with them; 1 hour for a conference with the total nursing staff, with didactic presentation of theory, case presentations, and evaluative discussions; and 11 hours in observation and participation in maternal and well-child conferences.

The theoretical framework underlying the program may be described as eclectic. Lectures on personality growth and development and some of the clinical teaching are based on psychoanalytical theories. Psychodynamic interpretation has been prominent as well as the concept of the effect of emotional stress on the body. Particular attention has been given to problems of interpersonal relationships and how to deal with them. The psychiatrist's methods of instruction evolved from her own on-the-job observations and the experience of others.[1, 3-5]

Individual conferences between the psychiatrist and nurses have the purpose of providing the nurse with a feeling of support, of recognizing and dealing with personal problems affecting the individual's work, and of offering each nurse a private opportunity to learn how to improve her handling of difficult cases or interstaff relationships. The nurses determine the subjects to be discussed. Rarely has there been a lack of material.

In the staff conferences the lectures have focused on personality growth and development, the major psychoses, and related subjects, sometimes with the use of films followed by group discussion. The case presentations are made and selected by individual nurses with the view of securing help not only from the psychiatrist but also from the group. The evaluative sessions have dealt both with the evolving mental health program and with group evaluation of problem cases.

One case presented in staff conference concerned a mother who had been in an iron lung for several years and had been recommended for psychiatric help but had not received it. Following the staff discussion of this case, the nurse who presented it was able to help the family to get the patient into a rehabilitation hospital for health supervision, both physical and emotional, and to help the family in other ways.

In addition to the nurses, the director of the health department sometimes attends the staff conference as do invited guests from other agencies—the social worker at the nearby tuberculosis hospital or a special education teacher from the public school system.

MCH Conferences

In participating in maternal and well-child conferences, the psychiatrist has found four types of consultative opportunities:

1. *Observing preconference interviews* makes it possible to note each nurse's individual way of getting along with the patient (or parent and child) and to suggest other possible approaches, either immediately after the patient has left, during the postclinic conference, or in private conference with the nurse. If the nurse does not feel the need for consultation, she is not "pushed" into it. The freedom with which the nurses have made use of the opportunity for consultation is indicative of their feelings of security. The psychiatrist always attempts to enhance this feeling.

2. *Occasional group sessions with mothers* conducted by the nurses provide an opportunity for the psychiatrist to help the nurse develop skills in working with individuals in groups. In these informal groups, the nurse finds herself in a situation where modes of behavior and interaction are often quite different from what they are in individual interviews or during a clinical examination. With the focus on such recurrent topics as children's behavior problems, discipline, eating problems, sleep disturbance, bed wetting, and how parents should deal with them, the nurse attempts: (1) to dispense information; (2) to give group and individual support to members; (3) to exert group pressures for change; and (4) to increase understanding and use of mental health principles.

The psychiatrist attends these sessions as a resource person for the nurse-leader, and afterwards serves as a consultant with the entire well-child conference staff—including nurses and doctors—in a review of what occurred.

3. *In accompanying the patient during the physical examinations,* the psychiatrist helps each staff member do a more thorough job at his own station and to integrate results of his particular area of contact with those of the next worker.

For example, a 3-year-old struggles furiously against submitting to the physical examination. The mother, embarrassed, slaps and sharply reprimands her child. The psychiatrist talks with the mother, helping her, and the staff as well, to feel more comfortable and to accept the child's behavior.

4. *Postclinic conferences* have been found to provide the most consistently significant learning experiences for the participants—three staff nurses, two student nurses, a clinician, and the psychiatrist. Case material is fresh; the observations of each participant may be compared before they are forgotten, and new meanings in patients' comments or reactions may be discovered. Through these conferences, the nurse responsible for followup can probe into her colleagues' impressions and judgments on various facets of the problems presented as she formulates the approach she will use when next visiting the family.

In structure, the postclinic conference is nonauthoritarian, the psychiatrist functioning as a group member as much as she does as leader. Responsibility is placed on the nurses and clinicians jointly to provide the material for discussion. The psychiatrist often asks questions intended to provoke discussion, and answers one question with another—but where specific psychiatric information will be useful, gives this directly.

If the participants feel secure enough for free discussion, the group members may comment on an individual participant's way of relating to the patient and give suggestions for meeting unexpected situations. They may discuss the question of whether time was used effectively in relation to the patients' needs rather than according to the nurse's or clinician's desire to follow familiar routine. They may also suggest ways of helping mothers to cope with problems connected with phases of emotional growth and development such as feeding and weaning difficulties, toilet training, thumbsucking, temper tantrums, bed wetting, and their own feelings of rejection. The psychiatrist repeatedly stresses the fact that skillful ability to listen is an invaluable tool for the professional person, which can result in great benefit to the patient.

Behavior problems, excessive anxiety, and personality traits of mothers and children observed in clinics have been discussed in these postclinic conferences, with the result that both nurses and clinicians are beginning to be more aware of variations among patients. They have revealed an increased ability to think through the dynamics of behavior and to search for adequate means of helping the patient.

In these conferences the psychiatrist often points out signs revealed in the clinic session of a patient's abnormal emotional or mental functioning or of normal variations of defense patterns, cultural differences, and personality characteristics. The purpose is to increase the nurses' and clinicians' ability to distinguish between normal, neurotic, or psychotic adjustment, and to determine which patients they can assist directly and which need referral elsewhere for treatment or other service.

As the conferences have progressed, an initial anxiety on the part of clinicians in regard to them—and the psychiatrist's role in them—has obviously decreased. The clinicians have begun to participate more, making contributions from their particular fields of medicine and pooling their experience and ideas in regard to mental health with that of the other participants.

Some Values

Through the process of sharing in postclinic conferences, nurse, psychiatrist, and clinician have come to new understanding of each others' skills, insights, functions—and limitations. Several times the overidealization of the physician's role has been evident,

and the common idea of the physician's "omnipotence" discussed. The clinicians have asked questions, made suggestions, and at times given evidence of some changes in their ideas or attitudes.

For example, during one postclinic conference it became apparent that the nurses resented the fact that the clinician seldom reviewed the patients' records or read the nurses' preconference notes. After this was discussed openly—for the first time—this clinician and the nurses were able to work together more effectively.

These postclinic conferences and other group situations in which interpersonal relations, interreactions, and communications problems are discussed freely have resulted in increasingly harmonious and effective staff relationships. The staff has exhibited a growing tendency to work out more satisfactory adjustments of inevitable differences.

Personality difficulties of the participants have occasionally emerged in staff group discussions. As yet, these have not been openly discussed in the group, but are dealt with indirectly or in a private conference. The individual conferences between nurse and psychiatrist also provide an opportunity for working through other individual blocks to optimum performance on the job.

One of the most needed changes in the nurses' attitudes has been to become realistic about limitations inherent in the public health nursing role. We believe that the program has achieved some success in this direction. As nurses have come to see why some patients cannot make better use of their service, they have substituted more realistic goals for overoptimistic ones. The psychic energy which was tied up in frustration over unrealistic efforts has then been released for use in more productive directions. For example, some nurses tend to keep cases open which might as well be closed because of the patient's or parent's lack of interest. When such a case is finally closed, the nurse can direct more time and attention to other patients.

We have learned that the nursing staff has had in reserve much awareness of the emotional problems of the patients with whom they have worked as well as a great deal of empathy with them. At the same time, however, they have hesitated to talk about these problems with their patients. The program has encouraged them to develop their empathy to the fullest and has given them support in bringing out in the open with the patient by question or comment the sensed areas of maladjustment, conflict, and anxiety. Most of the nurses have gradually come to see that in office interviews and home visits a considerable amount of their time can be profitably spent in exploring the mental and emotional health of the patient without detracting from the nurse's traditional concern for his physical health. In varying degrees and at different speeds, the nurses have become more comfortable in taking up with parents, at the appropriate time for the individual, problems connected with phases of emotional growth in children.

Briefly, the program seems so far to have produced the following results among the nursing staff:

1. Inclusion of mental health awareness in all areas of work.

2. Greater knowledge of the dynamics of human behavior and emotions.

3. An increasing awareness of the subtleties in interpersonal relationships and use of this sensitivity in working with patients.

4. A reassuring sense of confidence in working with patients in areas involving feelings.

In spite of some initial anxieties connected with the great deal of staff time spent in planning and the shifts in schedules required, no recognizable hostility has been observed or verbalized toward the program. Although some administrative snarls have occurred, there have been no apparent serious emotional snarls. It is, of course, impossible at this early stage to give objective evidence to substantiate feelings regarding the program's success.

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CASE CONFERENCES IN A FAMILY CENTER

HANNAH OPPENHEIMER
Caseworker, Huntington Family Centers, Syracuse, N.Y.

THE WORDS "case conference" hold a variety of meanings to many professional and lay people. Hospitals, schools, social agencies, health agencies, and probation departments hold case conferences in some fashion or other. Their general purpose is: to clarify and diagnose a problem, to transmit information to everyone involved with the problem, and to plan a course of action together to solve or in some way minimize the problem.

Case conferences have become almost routine with social agencies, whose staff members need to confer together periodically for planning how to deal with all the troubles, fears, and problems that their clients bring to them daily. And when many agencies are dealing with the same client, the agencies need to get together for the same purpose.

At the Huntington Family Centers of Syracuse, case conferences are an important part of the procedure in serving families and children. Huntington, a Community Chest-supported agency, operates two family centers in Syracuse. Both are located in deprived areas of the city and have identical functions and policies. The activities described in this article will be those of the East Side center, which provides casework and group-work services to 120 families in its immediate neighborhood, and group-work services to 80 additional children whose parents are not in the program.

Most of the families coming to the center have many problems. The focus is on comprehensive treatment of the whole family by the use of casework, group work, and community organization. The policy has been to reach out to young families, or other families with young children, where emphasis can be placed upon prevention rather than correction. The agency's aim is to try to help the family by strengthening family ties, preventing breakup, and promoting self-sufficiency in all members of the family.

A variety of programs have been designed in order to accomplish this purpose. First, there are the *homemaking groups* for mothers, conducted by a professional social worker who has specialized in group work. Then, there is a *nursery school*, led by a person trained and skilled in nursery education. These two programs operate concurrently in the early afternoon, three times a week. Next come the *after-school groups* for children 5 to 14 years of age. These groups are small and are led by volunteers, each responsible to and supervised by the group-work supervisor and his assistant, both also social workers who have specialized in group work. Individuals or families who are part of these groups are referred for *casework service*, when this seems called for, to the center's social caseworker. Casework treatment is provided on an intensive basis with one or more contacts per week.

The agency also operates a *clothing exchange* once a week, holds a *family supper* once a month in which all families are invited to participate, and holds *parent-education groups*. It also runs a *family camp* attended by a carefully selected group of families for whom the experience is regarded as a part of the treatment plan.

The reader can readily see that the staff members of the agency see the families from various angles and that close cooperation among them is necessary for a picture to emerge which will depict the family as a whole. This is accomplished during the weekly *case conferences*.

The following incident illustrates how a misconception can be dispelled when staff members work together.

The director and the caseworker were discussing a family that had attended the monthly family supper. The director commented on the fact that the father seemed to hide behind the dark glasses he was wearing. The caseworker, who had been to the home

earlier, told him that actually he was not hiding, but had broken his regular glasses and had to wear his prescription sunglasses instead. However, she said she felt that the father had acted with authority and protectiveness in selecting the head table and placing all his family around him. The director changed that idea by telling her that he, himself, had placed the family there.

This example shows how easy it is, even for professional workers, to jump to a conclusion, or have a biased opinion based upon very meager evidence. It also shows the necessity for close cooperation between all persons who deal with a family.

While there is a regular period for case conferences at Huntington, a conference can be called at any time during the week in an emergency. In any event, every staff member is presented at the conference and knows well ahead of time—usually at the end of the last conference—which cases are to be discussed. Usually two to three cases are covered during a 2-hour conference. The procedures are informal. As a rule the staff member who has had the closest contact with one of the family members—a child, a mother, a father—presents the case. Then each staff member gives his observations on the family. Following this, there is a general discussion which leads to an agreement on a plan of action. The group then decides if and when the case should be reviewed again.

The Bowers Family

For example, there was the conference on the Bowers family.

Mrs. Bowers, now 44 years old, had come from the rural South many years ago and had managed thereafter to achieve 2 years of a college education. She then met Mr. Bowers and married him. She learned later that he had been married before, and since no divorce had been obtained that her marriage was not legal; but she was not aware of this fact until after Mr. Bowers died in 1957. The couple had four children; Miriam, 11 years old; Charlie, 8 years old; Penny, 6 years old; and John, 5 years old.

The Bowers family has been participating in the Huntington program for about 3 years. The two oldest children came first to the group-work program. Then the mother joined a homemaking group and at that time brought Penny and John to the nursery.

During the summer of 1961, a change was noticeable in the Bowers family. The mother seemed more distraught. Charlie began acting up in his group, and Penny, who is a very stout little girl, demanded more attention and food in the nursery. The mother and the children were invited to attend the family camp. There the camp staff noticed that although the children seemed to be enjoying themselves the mother was preoccupied and under stress.

Until this time, Mrs. Bowers had been self-supporting, working as a cleaning woman, but shortly after she returned from camp she discovered she had high blood pressure and a slight heart ailment and could not continue in this heavy work. Therefore, she quit her job and applied for public assistance. When this happened, the agency decided to hold a case conference on the Bowers family. As Mrs. Bowers had requested some specific help around her financial problems, the caseworker called on her prior to the case conference to discuss these problems with her and to make a more systematic evaluation of the home.

The entire staff was present at the case conference, plus two graduate students of social work who were serving their field-work placement with Huntington. Having had the closest contact with the Bowers family, the family group worker made the presentation, which was supplemented by the caseworker with information she had gathered during her visit, and by the workers who knew the children in the nursery school and after-school program.

The family group worker described the mother as she had known her for the past 3 years, her participation in the homemaking groups, her attendance at the parent-education groups, and her stay at the

Some months ago, CHILDREN inaugurated a Case Conference feature to appear intermittently in the journal. The first "conference," which appeared in the May–June 1961 issue, was composed of a case story of a family with a variety of neglected health and family problems, and the comments of four persons, each of a different profession, to which the story had been submitted with the query: "Whose responsibility was it to see that this family received the appropriate service?"

As the result of this feature, the journal received a request to publish a report of an intra-agency case conference as it had actually been handled within one agency. The accompanying article is CHILDREN's answer to this request.

Readers are invited to contribute to the discussion of the Bowers' case, contained within this article, or of the article as a whole, through the "Readers' Exchange" section of subsequent issues of this journal.

camp. There emerged a picture of a woman whose attendance was good, who was serious about the job or the discussion at hand, who wanted to be respected by her immediate community as well as the larger community around her. The nursery school teacher substantiated this account by recalling that Mrs. Bowers was active in the PTA as well as her church.

During the ensuing discussion, however, it became clear that there was a self-defeating strain in Mrs. Bowers. Her standards and aspirations were high and definitely middle class. She was putting real pressure on her children to conform to these standards. However, she, herself, had difficulty in maintaining them.

Mrs. Bowers had never acknowledged the fact that her husband was previously married and that, therefore, her marriage was not legal. We had learned this fact from the Department of Public Welfare. She had made clear to us that she found it extremely difficult to accept public assistance, but despite her educational attainments she had done nothing to find a job that was less physically demanding than the janitor's job she had had to leave. Moreover, we had learned through the Department of Public Welfare that during her illness, which occurred 2 years after the death of her husband, she had had a miscarriage.

We knew from chance remarks of her older children that Mrs. Bowers was allowing men to come into her home and to stay very late at night. At the same time, she expressed concern about whom Miriam, the 11-year-old, associated with and about what she did at all times. When Mrs. Bowers was at the center with her children, she watched constantly to see that they behaved well—in other words, that they were quiet, clean, and did not quarrel among themselves or with other children. There was, however, a discrepancy between the children's personal appearance and the appearance of the home. The children were better dressed than most others coming to the agency. However, the family group worker in visiting the home often found the apartment in complete chaos—piles of dishes in the sink, laundry strewn about, and no evidence of any attempt having been made at sweeping or dusting.

Here then was a woman who was torn between the desire to raise her children and live according to middle-class standards and her knowledge that she was violating some of the rules of middle-class society. In some manner she must also have been aware of the fact that this discrepancy was apparent to her children, but because of her need to keep up appearances to the outside world, her pressures upon them to conform continued.

The group worker reported that Charlie was beginning to show more aggressive acting out of his inner problems and some signs of confusion about his own identity and ability. The nursery school teacher told us that Penny was no longer the happy, self-sufficient child in the nursery but had become more dependent and withdrawn.

We came to the following conclusions: Mrs. Bowers with the help of Mr. Bowers had managed well in raising her family, imbuing them with a sense of responsibility and independence. When he died she continued for a while to hold on to the values that she considered important. Little by little, however, she relinquished some of them and the resultant guilt feelings began to have an effect on her relationship to her children and hence on her children.

How much all this affected her physical health we could not tell, but we felt that it most probably had something to do with the heart illness she suffered in the summer of 1961.

Our next question during the conference was, of course, *what now?* How can we at Huntington be of best service to this family? Should we concentrate on the children and help them by way of our group-work services to make adequate adjustment in their life situation? Should we offer casework services to Mrs. Bowers, who as yet has not asked for this kind of help?

The group-work supervisor thought that Mrs. Bowers should be immediately faced with her problems as we saw them. He suggested that the family group worker, being closest to Mrs. Bowers, should tell her frankly what she was doing to her children by keeping this double standard, this pretense of being an upright, morally decent, self-respecting woman, without actually following the standards herself. He felt that this should be done for the sake of the children, because, as he saw it, Mrs. Bowers would become more and more disturbed in trying to keep up a middle-class façade without having sufficient inner strength to do so and without the support of reality. The children, after all, could see what was going on at home. On the other hand, the family group worker and the caseworker suggested that deflating Mrs. Bowers' middle-class self-image would be taking away the most important props and defenses that she had at this time, and that we had nothing at hand to substitute for them. Everyone agreed that we could not be very effective with the children unless we also helped the mother.

We finally decided that we could be of most help to Mrs. Bowers if we continued to support her by accepting her and her family as we had done all along. However, until now we had treated Mrs. Bowers as if she really were a strong person in her group at Huntington and in the outside community. Now our focus had to be shifted slightly.

The ground for this, we decided, would have to be prepared by the family group worker. Through discussion in the homemaking groups and in individual interviews, the group worker could help Mrs. Bowers to see that the type of problem she was struggling with—such as wanting to be respected, and raising her children properly while being involved with a man to whom she was not married—was not unique; that there were many other women in the group with similar problems. Through group discussion, Mrs. Bowers could also learn that accepting the help of a caseworker need not mean that she is a weak, incompetent person. In fact, she might emerge as a stronger and more effective mother and member of the community if she could understand herself better and learn to handle her problems in a more realistic manner. Thus Mrs. Bowers could be helped to see that seeking casework service would not be depriving her of her independence.

We knew that she trusted us and thought highly of us. We felt that this plan would succeed because she had an especially good relationship with the family group worker, and her attendance at homemaking groups had continued to be regular. At the same time, we planned to give greater attention to the children.

We also decided at the conference that our agency would offer to become the coordinator of the various community resources available to the Bowers—the Department of Public Welfare, which was giving the family an assistance grant, the Syracuse Dispensary where Mrs. Bowers was being treated for her heart ailment, and the schools where the children were enrolled. Mrs. Bowers had been wanting to move because of the physical demands that her home made of her. Our subsequent contact with the welfare department in which we were able to explain some of Mrs. Bowers' difficulties was sympathetically received and followed by action which enabled the family to move to an apartment that was more convenient and required less work and upkeep.

As a result of the case conference on the Bowers family, the staff learned the needs of the *total* family. Prior to the conference, each staff member in touch with a member of the Bowers' family had treated that person in isolation. Now it could be done as part of a concentrated effort. The next step then was to put our plan into action, and then after 3 months to meet again to see what progress had been made.

These things we did. At the followup conference we noted the following facts:

The older children's behavior had changed little, if at all. The youngest child seemed less anxious but perhaps even a little more aggressive than before. The biggest change had occurred in Mrs. Bowers. She had begun to understand a little how her problems affected her children. On several occasions she had come to ask for specific help from the caseworker, and finally within the last month she and the caseworker had sat down together and had considered what casework help could mean to her. She had then decided to use this service, plus continuing her regular attendance at the homemaking group.

The staff was satisfied. Even though the program was slow, it was having positive effects.

Some Principles

As with most cases discussed in a conference, the Bowers' case was selected a week prior to the actual conference to give the family group worker and others enough time to organize their material. We have found this procedure quite useful, as it eliminates the necessity of writing a formal case presentation. As the various staff members contribute their material, the caseworker takes notes which are then used as the basis of a short report prepared after the conference.

All families registered with the Huntington Family Centers are the subjects of case conferences at least once a year. Many have a second review after 3 months as did the Bowers family. Of course, if a crisis arises, a case conference can be held immediately. Since our focus is family centered, the total family is considered in each conference even though the precipitating problem may seem to involve only one member.

It is not always easy to keep a conference centered on the family under discussion. Many a time we have gone astray and found ourselves involved in some technical or theoretical problem that has had little or no relation to the case at hand. This was interesting and even educational, but of little value to the family under discussion. We, therefore, try hard to avoid such digressions.

One of the values of a good case conference that has not often been recognized is the help that the staff members give to each other during such a pres-

entation. For instance, during the Bowers' conference, the nursery teacher who had become increasingly troubled by Penny's behavior was made aware of the various pressures that surrounded the child at home. This made it easier for her to understand the child's behavior in the nursery and to deal with it. As the staff members present their views of the family, the total staff knowledge is enlarged and all can be strengthened by this.

Throughout our discussions of the Bowers family there was the underlying assumption that the family could be helped through the services that Huntington has at its disposal. A case conference can be completely fruitless if this is not the case. Every member of the conference must be aware of the help that the agency can provide. If the case under discussion requires different tools than the agency has at hand, this should be recognized immediately. Otherwise, a great deal of time can be spent on useless, even though diagnostically sound, behavior descriptions.

For example, at another conference held at Huntington we discussed a family consisting of a man and his wife and six children, who had recently been referred to the agency. This family was beset with tremendous health and financial problems which overshadowed every other aspect of the home. The staff spent considerable time in talking about the strengths and weaknesses of the various family members. The behavior of the parents was described and consideration given to the psychological impact this had on the children. When we were finished with this and set out to make a plan of action, it soon became apparent that our agency was not equipped to help the family until their major problems were met. What this family needed now was the help of the Department of Public Welfare and the Department of Health. If we had recognized this at the start, we could have saved ourselves and the client, a considerable amount of valuable time.

Whether the conference is an intake, an interagency, or an intra-agency conference, every participant must know what services can or cannot be offered and what the client can or cannot achieve with the help of these services. We have all sat in conferences where this factor was not taken into account, with resultant frustration for everyone concerned and a great deal of "passing the buck," either from one staff member to another or from one agency to another. In the meanwhile, the client and his problem recede into the background without receiving any effective help.

To summarize, at the Huntington Family Centers we have found case conferences most effective if they are conducted in the following way:

The conference is held in an informal atmosphere with all staff members participating. Cases for discussion are selected well in advance, priority being given to those facing crises. The focus is on the total family. Usually not more than an hour is spent on discussing one case. One staff member presents the case and the rest add what information they have about the family. The staff then arrives at a diagnosis and a plan of action is formulated. Notes taken during the conference are compiled and a short report is made.

If we feel that our agency is not equipped to handle a certain problem, we seek to find another agency that can do so, stating frankly that our agency cannot work with this problem and giving our reasons for coming to this decision. We have found that in this way we have streamlined the conferences and have been of greater service to our clients.

Any long-range attack on dependency requires that we understand better than we now do how we may help children in ADC and similar homes more adequately prepare for adult roles. As we all know, we have a particularly critical problem in a society that continues to move in a direction that makes a vast group of young people expendable so far as the labor market is concerned. It is estimated that there are nearly 1 million unemployed youth in the age group 16 to 25. How many of these will swell the ranks of deserting or putative fathers?

John M. Romanyshyn, professor of sociology, University of Maine, to the 1962 forum of the National Conference on Social Welfare.

A RELOOK AT THE EFFECTS OF MATERNAL DEPRIVATION

MILTON J. E. SENN, M.D.
Director, Yale University Child Study Clinic, New Haven, Conn.

VERY FEW publications in the field of research about human behavior have excited as many people as the monograph by John Bowlby,[1] dealing with maternal care and the mental health of children, published by the World Health Organization in 1951. Now with the publication of a new monograph, "Deprivation of Maternal Care—a Reassessment of Its Effects," * WHO has provided an opportunity to review the theories presented by Bowlby in the light of 11 years of perspective and the findings of new research.

A year or so before the publication of his 1951 report, Bowlby came to New Haven to talk with me about research in infant development which the late Katherine Wolf and others were doing at Yale University. He was aware of studies on the relationship of faulty infant development and maternal deprivation made by a few Americans, especially René Spitz, but he had not been informed of the carefully done followup studies of William Goldfarb, which then were recognized as extremely important but against which there already had appeared criticisms of the kind and severity which later were to be leveled against the Bowlby review.

Bowlby's intent was to gather the strongest evidence he could to prove to persons in the child care field that the quality of the psychological milieu in which infants are reared had decisive influence in shaping their personalities, and that the rights of infants included parental nurture of a highly personal variety. The effects of his painstaking study were immediately evident. Child welfare workers, along with psychiatrists and some pediatricians, began to appraise every type of institution caring for infants in relation to its ability to provide babies with all the things they needed as growing and developing human beings. Important changes were made in some of them.

For example, staffs of hospitals for children reviewed their visiting hour schedules for parents, frequently concluding that flexibility of scheduling not only promoted a healthier and happier relationship between the child, his parents, and the hospital personnel and prevented after-care anxiety, but also reduced some of the congestion and confusion of the visiting period. Social welfare workers set up new standards of optimum care, and when domiciliary institutions were unable to meet these higher standards their administrators were advised to close their doors.

Foster family homes began to be considered much more suitable than congregate care. In some places there was an extreme shift from institutional care to the use of foster family placement, completely excluding the larger institutions for children who could not be cared for by their own parents. With time, the error of this uncritical change has become apparent, and the belief is no longer so widely held that a foster home always is a "home," and that every large

*Prugh, Dane G.; Harlow, Robert G.; Andry, R. G.; Mead, Margaret; Wootton, Barbara; Lebovici, S.; Ainsworth, Mary D.: Deprivation of maternal care—a reassessment of its effects. WHO Public Health Paper No. 14. Columbia University Press, International Documents Service, New York, 1962. 165 pp. $2.25.

establishment is barren of intimate human experience because of its size. Realists among the everyday workers with infants have discovered that size per se is not the best gauge of suitability, and have concluded with Bowlby that the quality of care must also be examined more critically before hard-and-fast rules about proper care of babies bereft of rearing within their natural homes could be established.

It is not known how much of the Bowlby report has been read by Russians who work with children. They, of course, credit the theories on which they have based their extensive programs of child rearing outside the natural family solely to Russian patriots, especially Lenin, Pavlov, and Makarenko. However parochial that might be, the Russians have demonstrated how to provide children in residence with group-living experiences of many kinds which seem highly satisfactory in promoting the most favorable physical and social development. The foster family home is unknown in Russia, but the Russians can present good evidence for their belief that institutional care can achieve intimacy in interpersonal relations between surrogate parents and infants.

Criticism and Reassessment

The greatest criticism of the Bowlby report has come from scientists who have questioned the interpretations of the data and suggested a reassessment of them by more rigorous statistical analysis.

In view of the variety of criticisms in the past 10 years, many persons have attempted to review the problem of maternal deprivation in a wider perspective, and frequently have been stimulated to carry out new research to validate or disprove the conclusions which appeared in the Bowlby monograph. Bowlby and some of his colleagues at the Tavistock Clinic in London have been among those not content to let matters rest, and have sought to redefine their theories of how infants develop normally, and how they may be affected by such experiences as deprivation of mothering.

The World Health Organization has been aware of its own obligations, especially to workers in the developing countries who are attempting to set up optimum child-care resources for infants and children, to reassess the material presented in its publication, and to attempt to take the issues out of the area of controversy. In its customary fashion of careful and objective assessment, it invited a number of distinguished workers in child psychiatry and in the social sciences to discuss some of the concepts involved and to submit working papers which could be presented as a followup report. These are the contents of the new publication, issued as public health paper No. 14. They are informative and interesting essays on such topics as the subtle effects of covert deprivation, cultural influences and patterns of primitive behavior as viewed in a biological context, the role of the father in deprivation especially when it leads to juvenile delinquency, and critical reviews of research considered by an expert in social theory and a psychoanalyst.

The most noteworthy contribution in this monograph is that of Mary D. Ainsworth, who here serves in a way as the unofficial spokesman for Bowlby, yet presents challenging and informative opinions of her own. As a former associate of Dr. Bowlby at the Tavistock Clinic, Dr. Ainsworth is familiar with Bowlby's changed ideas about the theories involved and his attitudes about the criticisms which have been aimed at his thesis. Furthermore, she is a psychologist who has carefully studied the vast numbers of articles which followed the 1951 publication with the aim of gleaning from them the most pertinent data which would elucidate the mechanisms involved in maternal deprivation, of clarifying the chief controversial questions remaining and of stimulating new research. It is her conclusion that the last word has still not been said about the manner in which insufficiency, discontinuity, and distortion of maternal care affects young babies and children, how long the traumatic influences are noticeably operating, and what rehabilitative powers and practices are or should be available to undo any damage which has been suffered.

The Question of Reversibility

Although Bowlby at one time was criticized as being too Freudian in his theoretical conceptualizations and his interpretations of the mechanisms of deprivation, Mary Ainsworth is more eclectic and views the effects of deprivation through the theoretical frames of reference of learning theory and of ethnology as well as psychoanalysis. Her conclusions as to the opportunities for restoration to normal development after deprivation are somewhat more hopeful than those expressed previously by many other persons. She makes nine points about how to overcome impairment which should furnish professional persons with guidelines as to reeducational and therapeutic measures.

Provence and Lipton at Yale University, in a work about to be published, agree with Ainsworth's conclusion that judgments about the reversibility of

impairments attributable to early interference with development by deprivation, separation, or distortion in parent-child interaction seem to be very much dependent upon the level of assessment. The more superficial the assessment is of the evidence of damage incurred and of its later effects, the more possibility there seems to be of reversibility. As one uses better clinical observational methods, structured examinations and intensive followup, the better the assessment and the more evidence there is of lasting damage.

Even though the effects of deprivation may be more frequently changeable and more readily reversible than was believed in 1951, there is still evidence of a distinct limitation to the readiness and the extent of improvement in cases of severe impairment of long standing. Hence there continues to be a need for caution in considering placement of children, especially the appropriate age at which they are to be separated from parents, the nature of the separation, its length and duration, and particularly the characteristics of the substitute institution, whether it be a hospital, a foundling institution, or a foster home.

Everyone seems agreed that more research is needed to further understand the conditions which make for good mothering, whether this be in the natural home or outside of it. The saying of a well-known woman of the underworld, "a house is not a home," may be aptly paraphrased, "every parental figure is not a parent." As a reminder of this, the new publication by WHO, like its predecessor on the same subject, will prove of inestimable value and interest to social scientists as well as to workers in social welfare.

[1] Bowlby, John: Maternal care and mental health. World Health Organization Technical Monograph Series, Geneva, 1951.

Guides and Reports

ON THE SEASON: a report of a public health project conducted among Negro migrant agricultural workers in Palm Beach County, Fla. Robert H. Browning and Travis J. Northcutt, Jr. Florida State Board of Health Monograph No. 2. Jacksonville. 1961. 66 pp. Limited quantity free on request from the Division of Health Education, Florida State Board of Health, Post Office Box 210, Jacksonville 1.

The second of two monographs concerned with migratory agricultural laborers, put out by the State Board of Health of Florida, this publication reviews findings of a 5-year project in Belle Glade, undertaken by a multidisciplinary public health team of the county health department, to determine the health needs of these people and to develop services to cope with them.

STUDIES OF ILLNESSES OF CHILDREN FOLLOWED FROM BIRTH TO EIGHTEEN YEARS. Isabelle Valadian, Harold C. Stuart, and Robert B. Reed. Longitudinal Studies of Child Health and Development, Harvard School of Public Health. Monographs of the Society for Research in Child Development No. 3. Child Development Publications, Purdue University, Lafayette, Ind. 1961. 125 pp. $3.25.

An analysis of patterns of illness experience of 67 boys and 67 girls, in total and separate categories, showing relative frequencies of different illnesses at successive ages and throughout total childhood—illustrated by a large number of charts and tables.

SOCIETY AND HEALTH IN THE LOWER RIO GRANDE VALLEY: based upon the findings of the Hidalgo Project on differential culture change and mental health. William Madsen. Hogg Foundation for Mental Health, The University of Texas, Austin 12. 1961. 36 pp. 20 cents.

The product of 4 years of intensive study of folk customs, social organization, medical practices and beliefs among Mexican-Americans in three communities in the lower Rio Grande Valley, this description concludes with 14 recommendations to improve relations between modern medical and welfare workers and the Mexican-Americans needing help, in the interests of more effective service.

CAREER TESTING FOR SOCIAL WORK THROUGH SUMMER WORK EXPERIENCE: a guide to local communities in organizing a program for summer experience in social work. Council on Social Work Education, 345 East 46th Street, New York 17. 1961. 48 pp. 75 cents.

Based on the experiences of summer work programs in operation for college students who are potential social work recruits, this guide advises on such aspects of the summer program as objectives, organization, assignments, seminars, field trips, and financing.

ANALYZING SOCIAL WORK PRACTICE BY FIELDS. Harriett M. Bartlett. National Association of Social Workers, 95 Madison Avenue, New York 16. 1961. 69 pp. $1.50.

The pamphlet discusses the principles and ideas underlying social work, some variations in practice in different fields, and implications of these for the social work profession.

BOOK NOTES

COTTAGE SIX: the social system of delinquent boys in residential treatment. Howard W. Polsky. Russell Sage Foundation, New York. 1962. 193 pp. $3.25.

Contours of a delinquent subculture thriving among disturbed adolescents in a residential setting—and unwittingly reinforced by staff—emerge in this sociologist's account of his 8 months' stay as a participant-observer in a cottage of the "toughest" and oldest boys in a treatment center for disturbed children.

The author, who is on the faculty of the New York School of Social Work, undertook the experience to propose ways of bringing the informal social system of the cottage, which had been blocking therapeutic efforts, into the center's treatment orbit.

Drawing on a liberal fund of experiences and recorded conversations with his 28 cottagemates, the author demonstrates the nature of the subculture—as authoritarian, distrusting, threat oriented—and the staff's accommodation to it. He also traces modes of interaction among the boys and paths of upward social mobility from "punk" or "queer" to higher status roles.

The closing chapters hammer on the theme that conforming with the cottage values hinders the boy's transition to values of the professional staff, whose goals he is expected to achieve.

To close the gap in the two sets of values, the author argues for changing the center's policy of segregating aggressive boys; and for deeper understanding by the psychotherapists of the peer group culture, its impact, and the boy's role in it. His broad proposal is for dovetailing techniques of social intervention with individual therapy.

ON ADOLESCENCE: a psychoanalytic interpretation. Peter Blos. The Free Press of Glencoe, New York. 1962. 269 pp. $5.

I? I? What am I? . . . I, hey I! What is I? . . . asks the opening passage of a fragment from a teenager's poem quoted at the beginning of this book. *I is to create*, ends the passage, and with this as a theme the author of the book traces, within the frame of psychoanalysis, the fine threads that make the fabric of adolescent personality. The author, a psychiatrist with the Bronx Municipal Hospital of New York, reviews briefly the ways personality develops during preadolescence and then goes into an intensive discussion of adolescence itself.

He focuses especially on the ego during adolescence and its achievement of a new level of psychological homeostasis brought about through an organizing principle which the author terms, "the self"; and on the interplay of environmental determinants and emotional growth factors.

Though the author for the most part does not focus on psychopathology, he concludes the work with two examples of deviant adolescent development, one illustrating "the male syndrome"—prolonged adolescence—and the other, "the female syndrome"—pseudoheterosexuality—as displayed in delinquent behavior.

THE POLICE OFFICER AND THE CHILD. Mary Holman. Charles C Thomas, Springfield, Ill. 1962. 150 pp. $5.50.

This book by a policewoman in Bakersfield, Calif., offers guidelines on crime prevention to police officers, officials, and students. Beginning on the note that although children may be small, children's cases are not "little" cases, particularly when mishandled, the author "talks shop" to her colleagues, pointing out that a crime prevention program means more than planning to "keep 'vags' on the move" or to "clean out that drive-in where the no-good kids are hanging out. . . ."

Her central theme is that the keynote of a crime prevention program should be the concept that the individual policeman's mode of conduct and attitude toward children is a vital element in their formation of positive or negative attitudes toward law enforcement. Offered in six parts, the author's advice covers work with youth organizations; the techniques of interrogating in a broad variety of situations—including responding to the call of a belligerent parent wanting the officer to "scare" his stubborn 5-year-old into "going to the bathroom"; and meeting special problems such as dealing with the child victim of the sex offender. The author also suggests nuances of technique for enhancing police-child relations.

INSTITUTE ON JUVENILE DELINQUENCY. Southwestern Law Enforcement Institute, Southwestern Legal Foundation, Dallas, Tex., November 1961. Charles C Thomas, Springfield, Ill. 1962. 180 pp. $6.50.

The 13 papers in this book present various aspects of the problem of juvenile delinquency from the vantage points of juvenile judges, Federal consultants, educators, psychologists, attorneys, juvenile officers, and training school and camp administrators. They consider, among other subjects, the causes of delinquency, the role of the police in control, interviewing youthful offenders, processing of police referrals, and juvenile court philosophy.

EDUCATIONAL TELEVISION—THE NEXT TEN YEARS; a report and summary of major studies on the problems and potential of educational television, conducted under the auspices of the U. S. Office of Education. The Institute for Communication Research, Stanford, Calif. 1962. 375 pp. $1.

Contributed by educators and other specialists in the communication media, the contents of this volume report on four separate studies carried out by private research bodies, summarize the testimony presented before a television study panel of the Office of Education, and list guidelines and recommendations made by the panel. These favor, among other things, the organization of State and regional networks toward the ultimate creation of a "live," interconnected, educational television network. Among the subjects discussed are a projection for the next decade of television's role in education and its community job; ways to improve educational television programs; and financing, resources, and facilities.

HERE AND THERE

The Family

A strong image of the family as a source of stability during times of rapid cultural change emerged during discussions at the 5-day International Conference on the Family convened July 23 in Rabat, Morocco, under the sponsorship of the Royal Moroccan Government and the International Union of Family Organizations. Concentrating on family and youth problems that are being churned up by swift social changes in newly developing countries, some 200 delegates from family, youth, social service, and related organizations and official agencies in 38 countries—including 19 in Africa and Asia—took part in the conference's 3 work groups and in the plenary sessions.

Addresses by representatives of the African countries of Ghana, Mali, Algeria, the Republic of Central Africa, and Morocco were highlights reflecting the geographical and cultural orientation of the conferees.

The principal currents of discussion were on the evolution of family structure in countries undergoing social, economic, political, and institutional transformation: relations between parents and teachers, and family and school; the organizational structure of educational and vocational guidance facilities; preparation of young girls and women for domestic and family roles as well as for professional life.

Among other developments, these discussions revealed—

- A trend toward the setting up of ministries or departments of family affairs in national governments—since 1945, 17 countries have created such bureaus and affiliated them with the International Union of Family Organizations.
- A tendency, especially in Africa, to make a distinction between education and instruction, education being defined as aiming not only to develop the faculties but also to build up the personality into an integrated whole, fully aware of the problems of life.
- A growing awareness of the need for parent education to bridge the gap between parents who are living a traditional, tribal life and their children who have been drawn out of the tribal family by the rapid social flux; and a widely shared conviction that this gulf can be narrowed by the active partnership of parents and teachers.
- A commitment on the part of many countries to the democratic form of local organization in order to achieve desired goals.

Radioactivity

On August 1, in the Salt Lake City milkshed, after milk samples in July showed marked increases in the average concentration of radioactive iodine, the dairy industry shifted some dairy herds supplying fresh milk, from fresh pasturage to stored feed; and diverted milk from other herds to the output of butter, cheese, and other milk products, since the iodine in such products virtually loses radioactivity by the time they reach the consumer. The action was undertaken with guidance from the Salt Lake City Health Department, the Utah State Health and Agriculture Departments, and the University of Utah. Similar action was taken on August 17 in Minnesota, and was under consideration in Iowa. However, these measures were later abandoned.

The average concentration of radioactive iodine in milk in July was 580 micromicrocuries per liter in Salt Lake City, compared with an average that month of 40 micromicrocuries per liter for the 61 stations in the Public Health Service milk sampling network. Except for Laramie, Wyo., where the July average was 370 micromicrocuries, the average concentration of radioactive iodine in all other stations that month was below 100 micromicrocuries.

The procedure of placing dairy cattle on stored feed was developed from research conducted in the fall of 1961 by the Public Health Service and the U.S. Department of Agriculture. The milk industry reportedly considers this to be the least disruptive to milk production and distribution among various procedures suggested for reducing the intake of radioactive iodine from fresh fluid milk by the population.

The chief guides which had been used as a basis for shifting the herds in Utah and Minnesota were the "Radiation Protection Guides," published by the Federal Radiation Council in the *Federal Register* of September 26, 1961. However, on September 10, 1962, the Federal Radiation Council adopted a statement, later released to the press, pointing out that the Council would not have recommended such action.

According to this statement, while the guides establish "a graded series of appropriate actions related to three ranges of transient daily rates of radioactive materials by exposed population groups," they are not presented as dividing lines between safety and danger in actual radiation situations "nor are they alone intended to set a limit at which protective action should be taken."

The statement maintains that individual fallout situations require individual evaluation which "must involve a careful examination of the source and magnitude and duration of the probable exposure levels as well as the health significance of the probable exposures balanced against the total impact of health protective measures."

The Council announced its intention to prepare a report on fallout summarizing the known physical phenomena, the health implications, and the present surveillance network, and discussing the applicability of possible countermeasures.

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The University of Maryland School of Medicine is undertaking a comprehensive research program on the response of living cells to high-energy radiation. The studies, which are being financed by a $150,000 grant from the National Cancer Institute, Public Health Service, will focus on such factors as the effects of radiation on cellular nutrition, rate of growth and division, metabolism and oxygen concentration; the interrelationships between chemical agents and radiation; and the importance of the tumor bed in the development and treatment of tumors. The program is being directed by Dr. Fernando G. Bloedorn, head of the department of radiotherapy at the university hospital; it is being conducted

in the department of radiology, headed by Dr. John M. Dennis, professor of radiology.

Services in Housing

The first project of "concerted services" for families in public housing developments, sponsored by the Joint Task Force on Health, Education, and Welfare Services and Housing, was launched last summer in the Pruitt-Igoe public housing development of St. Louis. The project's goal is to demonstrate, through the combined efforts of Federal, State, and local public and voluntary agencies, how coordinated health, education, and welfare services can be applied to the needs of the 2,600 families in this low-income development—half of whom are receiving public assistance—as well as to the needs of other persons living in the neighborhood.

The 30-member task force was formed in March to identify services needed by families in such housing developments and to arrange for providing these developments with a concentration of appropriate services. (See CHILDREN, May–June 1962, page 124.)

One of the reasons St. Louis was selected last June as the scene of the first project was that the city was giving major attention to the needs of public housing residents as a result of a study made by a local committee on public housing and social services appointed by the mayor in 1960. For example, a local office of the State welfare department was already in operation within the housing development, and the local health department had set up a maternal and child health center across the street.

The local housing authority is making space available for other services, which will include an information and referral center. Other agencies planning to locate offices in or near the housing project are the Federal Bureau of Old Age, Survivors, and Disability Insurance, and the Missouri State Employment Service.

Local social, health, and education agencies have promised to give high priority to the problems of people living in the Pruitt-Igoe development and the neighborhood, with the major responsibility for individual families to be carried in each instance by a single agency charged with bringing to bear all the indicated services.

Overall policies for the project are formulated by an advisory and planning board, with appropriate functional committees. Appointed by the mayor, the board is composed of members of local coordinating bodies such as the Health and Welfare Council and the Metropolitan Youth Commission; appropriate departments of State government; and professional, service, and civic groups. A newly created Community Services Division in the St. Louis Department of Welfare is responsible for the coordination of services under the board's policies. Technical consultation is provided by the task force and the HEW regional office in Kansas City. The regional office is also working with Missouri agencies of the State government in helping to channel available resources to the area. For example, $25,000 worth of surplus machine tools have been allocated to the St. Louis school system as training aids in the vocational education program.

The availability of research resources at Washington University was another factor which led to the selection of St. Louis as the scene of the demonstration. The university has agreed to conduct research aimed at: (1) evaluating the effects of the project on the individuals served; and (2) identifying effective methods of service coordination that can be applied to other areas.

Federal Legislation

A bill authorizing a program of Federal aid for health care of the Nation's million migrant farmworkers and their dependents was signed into law in late September. The legislation authorizes the Public Health Service to make project grants for health services up to a total of $3 million a year for the next 3 years to State or local public health agencies or other nonprofit agencies and institutions in States through which migratory farmworkers stream each year to harvest crops. The funds are to be used to help finance the cost of establishing and operating health clinics for such workers and their families, and for otherwise improving health services for and health conditions among such families.

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In October the 87th Congress amended the Public Health Act to authorize the establishment by the Public Health Service of an Institute of Child Health and Human Development. The Institute's functions are to conduct and support "research and training relating to maternal health, child health, and human development, including research and training in the special health problems and requirements of mothers and children and in the basic sciences relating to the processes of human growth and development, including prenatal development."

To avoid overlapping of effort, the Public Health Service and the Children's Bureau have developed a working agreement. The Children's Bureau will concentrate on improving the development, management, and effectiveness of maternal, child health, and crippled children's services, while the Institute's research programs are to be directed toward the development of new knowledge relating to health problems and requirements of children and the phenomena of human growth and development.

For Health

By the end of last summer, 44 community health studies and demonstrations were underway in various parts of the country, with the help of grants from the Public Health Service, authorized under the Community Health Services and Facilities Act of 1961. Purpose of the grants is to develop new or improved methods of providing health and medical services. Totaling $2¼ million, the grants were made to public and nonprofit organizations, including State and local health departments, hospitals, universities, and professional organizations.

Among the projects are:

- Two demonstrations—in Dade County, Miami, Fla., and Monroe County, Rochester, N.Y.—on the coordination of public and voluntary health organizations in a communitywide program of comprehensive health care.
- An experiment at the University of Southern California, with the use of electronic computers in storing and retrieving information on all patients known to hospitals, nursing homes, and health and welfare agencies in Los Angeles.
- The establishment by the Rip Van Winkle Foundation, Hudson, N.Y., of nonprofit supplementary services to patients of a group practice clinic providing both medical and dental services on a prepaid plan. The added services

will include home nursing, physical therapy, nutrition counseling, social casework, dental hygiene, and medical specialty consultation.

• A 3-year study to be undertaken by the California Medical Education & Research Foundation to develop methods of assessing the quality of medical care in the practice of individual physicians.

• A long-range study by the Group Health Association of America to develop basic data on the use of specific health services in a large population group according to age, sex, socioeconomic status of the users, and other factors.

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A conference on Standardization and Maintenance of Nomenclature and Comparable Clinical Statistics in Obstetrics, Gynecology, and Pediatric Care of the Newborn was held in the Children's Bureau on September 27, 1962. The meeting was attended by representatives from the American College of Obstetricians and Gynecologists, the American Hospital Association, and from university departments of obstetrics and gynecology, pediatrics, and of maternal and child health, as well as interested offices in the Department of Health, Education, and Welfare, and the Medical Corps, U.S. Navy.

It was decided that leadership should be provided by the American College of Obstetricians and Gynecologists in formulating and carrying out a program for standardizing terms in the medical specialties especially concerned in the areas of maternity and infancy. The American Academy of Pediatrics and other interested professional groups will be asked to collaborate. The work of the program will be coordinated with the current medical terminology project of the American Medical Association.

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The Community Service Society of New York City has recently released a report of a pilot demonstration of family-centered public health nursing services in the homes of maternity patients in an underprivileged area of the city. Completed in June 1961, the project was begun 2½ years earlier, with the collaboration of the city health and hospital departments and the New York Medical College-Metropolitan Hospital Health Center. The purpose was to assess the feasibility and effectiveness of the service offered as a supplement to the usual municipal hospital services and to develop criteria for selecting families most able to benefit from it.

Among patients receiving prenatal care at a municipal hospital, 225 were selected at random and divided into a control group and a service group. Of the latter, 80 patients received the full service for themselves and families during the maternity cycle and at least 4 months after confinement. Provided by five nurses, this service entailed mainly individualized health guidance in meeting immediate problems, from dental caries to diabetes, and in acquiring self-direction in health matters.

Substantial gains were noted in many of the served patients' physical health, nutritional practices, and physical and psychological readiness for delivery. Found most able to benefit from the service were patients with the most concern about the family's health needs and apparent capacity for productive interpersonal relationships.

Entitled "Serving the Maternity Patient Through Family-Centered Public Health Nursing," the report is available on request (until supplies are depleted) from the society, 105 East 22 Street, New York 10.

Dental Care

The likelihood that specific oral manifestations of retardation, such as drooling and tooth grinding may, in some instances, be due to dental pathology rather than retardation, is pointed up in preliminary findings of a pilot study involving dental work on 47 child patients at the Institute for Retarded Children of the Shield of David, New York. Reported at the annual conference of the American Association on Mental Deficiency in May, the study covered children with severe dental problems including abscesses, pulp exposure, and periodontal diseases, treatment of which brought these results: of the children reported as drooling, 50 percent stopped; of those reported as grinding their teeth, 66.6 percent stopped; among those reported as not chewing, 63.6 percent began to chew; of the poor eaters, 38.09 changed to good eaters; and of those who habitually placed miscellaneous objects in their mouths, 35 percent stopped. Among the children who awakened crying during the night, 53.9 percent began to sleep through. These results represent the correlated answers to questionnaires from parents, teachers, and the school psychologist during the week after treatment.

Explaining how each of the oral manifestations can be caused by dental pathology, the report points out, among other details, that since the process of swallowing calls for the meeting of the lower and upper teeth and that such contact is painful in the case of an abscessed tooth, when such a condition exists in a retarded child—many of whom find difficulty in making known their complaints—they tend to avoid swallowing and to keep their teeth apart, and thus drool; and also that it is common for a person to grind on a tooth around which gingival inflammation exists.

. . .

A grant of $152,758 was recently awarded by the National Institute of Dental Research, Public Health Service, to the Columbia University School of Dental and Oral Surgery for a 3-year graduate program of training dentists for careers in research and teaching in the field of dentistry for handicapped children, especially those who because of neuromuscular conditions cannot sit still in the dental chair.

The Columbia program in treating handicapped children, dating back to 1951, stems from the efforts among parents of cerebral palsied children in the 1940's to obtain dental care for their children and from the efforts, in turn, of a group of interested dentists to gain the cooperation of a dental school in developing the program. Since the program was initiated, about 1,200 handicapped children, including about 1,000 with cerebral palsy, have been treated at the school's clinic, which is one of four such clinics sponsored by the New York City United Cerebral Palsy organization. Its fellowship program has been supported by the United Cerebral Palsy Research Educational Foundation.

Child Welfare

"New Goals and Directions in Child Welfare—1962–75" was the theme of a regional child welfare meeting held by the Children's Bureau in Charlottesville, Va., July 9–11, 1962. Representatives from public welfare and public health agencies in six States in region III participated in the meeting.

The group gave special attention to the need for more effective recruitment methods for child welfare staff; for better understanding of public child welfare in schools of social work; and for more fieldwork placements in public child welfare programs for students attending graduate schools of social work. Licensing and consultation, especially in the area of day care, were also the subjects of considerable discussion. Special attention was given to the function and responsibility of public welfare, education, and health agencies in establishing standards for licensing and for providing consultation to day-care operators and boards and for interpreting the meaning and importance of licensing to the public.

From data provided through questionnaires sent to the State welfare departments in preparation for the meeting, the Bureau's regional office is preparing a comprehensive report on licensing in the eight jurisdictions comprising Region III—Kentucky, Maryland, North Carolina, Virginia, West Virginia, the District of Columbia, Puerto Rico, and the Virgin Islands. The report will provide information on State licensing laws, standards, agencies responsible for licensing, numbers of licensed child-caring agencies and day-care centers, types of licenses granted, types of disciplines involved in the development of standards, implementation of licensing standards, use of advisory committees, educational programs for licensing staff and for the staff of the facilities to be licensed, and other details.

The purpose of the report is to help States and the Children's Bureau in determining areas where improvement in licensing laws is indicated, where strengthening of licensing staff is needed, and where more effective coordination is needed between welfare, health, and education authorities in developing adequate standards for day-care services, as well as for other types of child-caring facilities.

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As one response to an expressed interest of the Committee on Appropriations of the House of Representatives in increased use of Federal funds to strengthen programs for young unmarried mothers, the Children's Bureau has recently assembled facts on child welfare services relating to illegitimacy, needs not being met, and plans for improving such services. Information was obtained through questionnaire responses from the departments of public welfare of 49 States, the District of Columbia, Puerto Rico, and the Virgin Islands, as well as from other sources of statistical data.

The findings show that in every State some service is provided to unmarried mothers by public child welfare agencies, though amount and type of service vary widely. The most frequent types of service available are casework service to help unmarried mothers plan for themselves and their babies, and adoption services. Foster family care, especially for the baby, is nearly as prevalent. Maternity home care and medical care for unmarried mothers are purchased by public child welfare agencies from maternity homes, hospitals, or physicians in about one-half of the States, and in some counties of a number of other States.

Preliminary data obtained from a study of the characteristics of all children receiving child welfare services show that one-half of the unmarried mothers being served by public child welfare agencies on a given day in 1961 were living with parents or relatives and 16 percent in independent living arrangements, while one-fourth were in foster family homes or maternity homes. Four-fifths of them were under 21 years of age. Three-fourths were white. Two-thirds were from families not receiving public assistance.

Data from other Children's Bureau reports show that voluntary child welfare agencies (not including maternity homes) serve twice as many unmarried mothers in a year as public child welfare agencies. All maternity homes are under voluntary auspices.

Comparison of service figures with available figures on all births out of wedlock indicate that each year about one mother in six who bears a child out of wedlock is served by either a public child welfare or a voluntary child welfare agency.

A full report on the data assembled will be published by the Bureau in the near future.

Law and Social Work

A new national body to enhance understanding and active cooperation between lawyers and social workers, the National Conference of Lawyers and Social Workers, has recently been established by the American Bar Association and the National Association of Social Workers. Composed of eight members from each of these professions, the new group met for the first time on May 27 to plan its activities and procedures.

The purposes of the organization are: to draft principles outlining legitimate activities of social workers and lawyers in areas of vital interest to both, such as juvenile delinquency or adoption; to delineate and give advice on areas in family law within the competence of lawyers and handle complaints about infringement of legal practice; to divide activities between the two groups relating to the development of legislation and suggest proper areas for mutual consultation; to distribute information on research projects; and to undertake activities to promote better understanding between the two professions.

At the May meeting, the group decided to begin developing principles in regard to adoptions and the relationships between lawyers and social workers attached to courts. Proposals deferred for future consideration include the development of local legal-social work forums, the issuance of a statement on the use of paid legal consultation by social agencies to increase understanding of legal implications in case situations, and joint teaching or joint research programs. The next meeting is scheduled for early 1963.

The new body is a result of recommendations made by the Family Law Section of the American Bar Association and the Committee on Lawyer-Family Agency Cooperation of the American Bar Association. Cochairmen are Sol Morton Isaac of Columbus, Ohio, representing the American Bar Association, and Jacob T. Zukerman of New York, representing the National Association of Social Workers.

School Dropouts

During August, the Urban League of Greater New York launched a "success center" for high school dropouts which combines the services of several agencies to enhance the job futures of these youths. The center, located in Harlem, is scheduled to run for a year on a $75,000 grant from the New York State Division for Youth, made through the New York City Youth Board.

The primary function is to encourage

school dropouts to return to school for some kind of training. Those unable to resume formal schooling are stimulated to undertake appropriate training outside of school.

The project employs a special staff of administrative social caseworker, psychologist, vocational guidance specialist, and work supervisor, providing diagnosis and treatment of the personal, social, family, psychological, and vocational problems that probably underlay withdrawal from school. In addition, a youth employment service counselor has been detailed to the center from the New York State Employment Service.

The Harlem program is one of eight youth and work training programs financed by the State division for youth. The Police Athletic League, the YMCA, Vocational Advisory Service, and East Harlem Y.E.S., Inc., also operate programs under subcontract with the New York City Youth Board, and in Buffalo, Rochester, and Syracuse similar programs are operated directly by local youth boards.

. . .

In St. Louis, Mo., a total of 2,579 youths dropped out of school during the 1960–61 school year, according to a study recently completed in the city's public school system by Dr. George Mowrer. Dropping out was attributed principally to "general lack of interest" (688); "reasons unknown" (533); "entrance into the armed services or employment" (485); and "marriage or pregnancy" (291). Of the total group, 26.4 percent withdrew in the 9th grade; 30.5 percent in the 10th; 23.5 percent in the 11th; 15.8 percent in the 12th; and 3.4 percent in other grades.

Adoption

A 3-year study of adoption in New York State recently completed by the New York State Committee on Adoption found that 21 percent of the children under the care of 96 foster care agencies in the upstate counties in 1959 were "presumptively adoptable"—19 percent of the white and 27 percent of the nonwhite. Among these, 52 percent of the white children and 82 percent of the nonwhite children were categorized by the agencies as "hard-to-place." Among the white hard-to-place children, age or "legal aspects" were named as the chief barriers to adoption for 69 percent, and physical or emotional handicaps for 19 percent; but race was the chief barrier cited for three-fourths of the nonwhite hard-to-place children.

Similar deterrents to adoption were reported by 77 adoption agencies, both upstate and in New York City, which had 2,648 children under study for adoption, about 62 percent of whom were considered hard to place—47 percent of the white children and 92 percent of the nonwhite children. Again the only barrier to adoption named for three-fourths of the nonwhite hard-to-place children was race.

The study committee proposed, among other recommendations, that—

- A child's adoptability be determined and placement made at the earliest possible time.
- Ways be explored for finding more adoptive homes for the hard to place, including increased spread of information, use of adoption clearance services, and experimentation with short-term financial aid to adoptive parents.
- Adoption practices be flexible enough to be adapted to the changing needs of children.
- Full use be made of the 1959 amendment to the State's adoption laws that created a new legal category of the "permanently neglected child."

The proposals also urged increasing the degree and quality of teamwork among the professions in the adoption process.

The study was sponsored by the State Charities Aid Association and the New York State Association of Councils and Chests, which have published the report under the title, "Facts to Build On; a Study of Adoption in New York State."

. . .

A new Kentucky law on adoption, designed to give more protection to children and adopting parents and to end black-market traffic in babies, became effective June 14. The law contains a requirement that a child for which adoption is sought must have been placed for adoption by a licensed child-placing institution or agency or by the department of child welfare or with written approval of the commissioner of child welfare. Penalties for violations include fines not less than $500 nor more than $2,000 or jail terms up to 6 months, or both. The law provides for exceptions in instances of adoption by close relatives or of children received from an approved agency in another State, with the commissioner's written consent.

Accident Statistics

A study of injuries involving toys and playthings sustained by children in Florida was recently conducted by the Florida Pediatrics Society, the Florida chapter of the American Academy of Pediatrics, and the Florida State Board of Health, with the sponsorship of the Toy Safety Committee of the National Safety Council. Pediatricians, general practitioners, and staff of emergency wards provided information on 748 such injuries treated during the months of June 1960, October 1960, and February 1961, revealing that nearly three-fourths of the accidents occurred to children under 6 years of age. Bicycles and tricycles were the playthings most commonly responsible in about 22 percent of all the accidents studied.

According to information obtained from parents of 54 of the children, there was lack of supervision at the time of the accident in 24 cases; in 10, the children did not have proper knowledge regarding the correct use of the playthings; in 14, the playthings were not used in a proper manner; and in 18, the injury occurred through the actions of other individuals.

. . .

Among the estimated 800,000 or more cases of accidental poisoning that occur yearly in the United States, the U.S. National Health Survey reports that almost 40 percent are in children under 5 years of age. The National Clearinghouse for Poison Control Centers, Public Health Service, has received reports for 1960 from 213 poison control centers of about 29,000 accidental ingestions by children in this age group, internal medicines having been involved in the largest number of cases. Thirty-three of these cases in 1960 resulted in death. In 1959, accidental poisoning from solid and liquid substances by children under 5 claimed almost as many lives (456) as did septicemia and pyemia (560), and ranked above meningococcal infections (441) and dysentery (223).

The Clearinghouse lists 490 poison control centers in 48 States and the District of Columbia, Canal Zone, Virgin Islands, and Guam. Of these, 442 give treatment as well as serve as information centers.

READERS' EXCHANGE

SORENSON: *Vs. youth participation*

Roy Sorenson's article in the July–August 1962 issue of CHILDREN ["Youth's Need for Challenge and Place in Society"] is on firm ground in pointing out certain focal problems of youth such as the problem of identity, of self-esteem, of alienation, of privatism, and of lack of commitment to adult values and goals. I am also impressed by Mr. Sorenson's challenges to adults to help meet youth's need for (1) competence in self-fulfilling activity, (2) understanding, (3) a truer public image, (4) work and responsibility, (5) recognition of excellence in areas other than athletics, and (6) commitment to a better future for mankind.

Where I lose contact with Mr. Sorenson is in his discussion of the youth subculture as if this were, merely because of its existence, a desirable expression of youth. I cannot join those dedicated to recognizing youth as a separate category of the human species, entitled to set up shop as a culture or civilization all its own.

Youth exists by virtue of the labor of others; it has not produced anything and does not, in the main, have the education or experience to make worthwhile judgments on the larger or smaller issues of our time. In short, I am opposed to a child-oriented or a youth-oriented society.

What I am interested in is that through an effective family system for child rearing and through a much more capable system of public education than we now have, plus better religious training and better private agencies, every child will be exposed to and in some siguificant measure absorb the best values of our Western civilization and become an effectively functioning individual within the framework of the adult society. I regard youth as a period of adaptation and training to occupy ultimately an intelligible place in the adult world.

I would develop every youngster with a good critical sense in reexamining much of the tenets dominating our thinking, but willing to conform to the existing framework until he can find something at a more mature age that he is convinced is better. I am not interested in making a cult out of adolescence.

I would not have any youths participating in the 1970 White House Conference as they did in the 1960 conference. While I would favor any statewide or national gathering of youths with the same focus, I think it is a little presumptuous for youth to undertake to dictate or to advise elders concerning the management of the family and of organized society when they are the recipients and not the determinants of whatever adult society has to offer them. It seems absurd to have a gathering of adults of all ages and professions, including many of distinguished competence in the human engineering professions, and allow them to be outtalked and shoved aside by a claque of assertive and ambitious youngsters.

Thus, I differ with Mr. Sorenson in some of his basic assumptions and would revert in some degree to the old rule that "children are to be seen and not heard," and are to apply themeslves to such measures of thought and action as will fit them to become part of the adult world in its existing culture. That culture is far from perfect, but I am not prepared to turn it over to the adolescents for remaking. I don't mind them trying later on when they are a little older.

Chauncey M. Depuy
President Judge, 39th Judicial District of Pennsylvania, Franklin County, Chambersburg, Pa.

Author's reply

Judge Depuy's letter warrants attention because it reflects rather widespread adult views about youth:

1. The *say it isn't so* attitude that would ignore the phenomenon of modern youth and belittle its manifestations.

The fact is that adolescence in today's urban industrial society, because of the unprecedented length and relatively recent detachment from responsibility, bears striking differences from adolescence in mankind's long past. Twenty million young people in America suspended between childhood and adulthood for the better part of 10 years is a sizable segment of the human species and deserves a category, as much as do infants, children, adults, and the aged.

Adults cannot escape their obligation to understand the varieties of teenage culture and why they arise by protesting that young people are not "entitled to set up shop as a culture or civilization of their own." Subcultures, whether racial, economic, professional, suburban, rural, urban, regional, or teenage, share in common the fact that they arise from external pressures as well as internal forces. Teenage subcultures are spawned by urban, industrial society all over the world. To recognize that the lot of teenagers in the affluent society has resulted in the varied coping mechanisms (some useful, some destructive) is not to make a "cult of adolescence," nor is it to imply that youth is allowed special privilege.

2. The attitude which says, *let's keep them in their place.*

The judge's words indicate that he is representative of that large segment of adult society which is not about, as he puts it, ". . . to be outtalked and shoved aside by a claque of assertive and ambitious youngsters."

Assertive youngsters? We should begin to worry when they have nothing to assert. Ambitious youngsters? Where will we be tomorrow if they are not ambitious? Youth-oriented society? A slight shift youthward will scarcely rock the boat of adult-oriented society. Young people who exist by virtue of the labor of others? Whose fault is it that our grown boys cannot find a man's work to do? Why should we adults clutch with so much grimness our monopoly on responsibility and resist finding appropriate ways of sharing some of it with youth?

Adolescents (who are not children) will not grow into the kind of adults we want by keeping them in their places, but by having more opportunities to function along with adults in the real tasks of community and nation. If we move over and make room for youth with good humor and grace, we won't have to worry so much about being "shoved aside."

3. The attitude which says *improve*

the historic child-rearing institutions and let's not worry about societal forces.

By all means improve the child-rearing institutions. They need it. And they will be improved and their effectiveness multiplied when they take into account the societal forces which have made the world troubling for older adolescents and which have crucial impact upon our institutions as well. Home, school, church, and agency need broader youth-in-society understanding and program if they are to do their job in these times.

Relying on the older, individual-centered methods still honored by the historic guardians of the young will not provide challenge, responsibility, and larger place for older youth. Adult institutions must blend their older functions with larger efforts to understand and to upgrade youth's opportunities for real involvement with adults in the tasks of the times.

Roy Sorenson,
General Secretary, YMCA of San Francisco, Calif.

HORNECKER: *Credit to the team*

In her article in the July–August 1962 issue of CHILDREN ["Adoption Opportunities for the Handicapped"] Alice Hornecker has most adequately pleaded for a different, more positive approach to the adoption of handicapped children. The achievement of this goal would be an advance of great importance and of lasting benefit to society.

There is, however, a danger in her presentation of which we should be aware, especially as we work in conjunction with physicians or other professional auxiliary to medicine. Without its being explicitly stated, the idea is conveyed that most of the marked improvements in the children discussed occurred because of the very adequate foster home or adoptive placements in a manner primarily independent of any other help the children received, rather than in conjunction with this other help. This is especially true in the case of Jimmy whose IQ jumped from 36 to low normal in 6 months, and in the case of Mack who was born without legs.

For both boys many services were rendered in addition to the tender loving care given by foster parents, and these services contributed much to their rehabilitation. Certainly no experienced social worker would discount the benefits for such children of an adequate home and devoted parents—natural, foster, or adoptive—but I feel we must also guard against an unreal assumption that this is the whole answer. This assumption need not be conscious. Indeed, it is more insidious when it is not conscious.

In all work with handicapped children, we must constantly remember that it is the team effort of many interested persons and not social work alone which is responsible for improvement. Without other services, the social worker would be in an impossible position in trying alone to effect changes in handicapped children.

A. W. Lockner
Supervisor, Medical Services, Social Service Department, the Montreal Children's Hospital, Montreal, Canada

BECK: *Rebuttal*

The May–June 1962 issue of CHILDREN [p. 102] contained an excerpt from Bertram Beck's comments at the 1961 forum of the National Conference on Social Welfare entitled, "The Myth of Prevention." The gist of the excerpt is that prevention is a concept suitable to public health but not to social welfare "where it is wholly inapplicable." In his argument, Mr. Beck makes essentially three points:

1. *The nature of health and welfare problems.* Mr. Beck argues that the nature of social welfare problems is fundamentally different from those of public health: Welfare problems, such as juvenile delinquency, are multicausal phenomena, extremely complex in nature and the result of complex chronic disorders. In contrast, public health problems, such as smallpox, are relatively simple phenomena with clearly identifiable "etiologic agents."

2. *The methods of intervention and control in health and welfare problems.* On the foregoing basis, Mr. Beck asserts that social welfare problems require different methods of control and intervention. Immunization, a preventive method, is feasible for public health but cannot be used for welfare problems such as juvenile delinquency.

3. *The populations involved in health and welfare problems.* Mr. Beck also argues that the segments of the population involved in health and welfare problems are dissimilar: Welfare problems are derived largely from the lower socioeconomic segment of the population, the "hard to reach." Public health problems, such as smallpox, in contrast, affect all segments of the population. While it is appropriate, therefore, in dealing with smallpox to pay as much attention to the healthy "easy-to-reach" middle and upper classes of the population, this is not true for juvenile delinquency, which is largely confined to lower socioeconomic levels. Intervention and treatment of the "easy-to-reach" middle class group, he argues, will have little or no effect on delinquency rates because juvenile delinquency is not essentially a middle-class problem.

I shall take these points up separately in the following rebuttal:

1. *Public health interest is not confined to acute infectious disorders,* such as smallpox. In fact, public health is increasingly concerned with the complex, chronic, somatic problems such as cancer, arthritis, and heart disease, the nature of which is not unlike the complex, chronic problems in social welfare. Moreover, social welfare, as the study of the literature will reveal, is developing an increasing recognition and concern for acute emotional disorders and crises, comparable in many ways to acute infectious disorders such as smallpox.

During World War II and the Korean action, some thought and experimentation was devoted to the possibility of "immunizing" people against the effects of certain emotional hazards such as bombing raids on the civilian population. The etiology and epidemiology of acute emotional disorders, in many but not all ways, parallels the acute somatic disorders. In fact, we are coming to see that the natures of the total range of problems of public health and of social welfare are more alike than different.

2. *The approach to welfare and health problems is therefore not fundamentally different* but quite comparable in relation to the types of problems of concern—acute or chronic. The problems of juvenile delinquency and cancer, for example, are comparable in the complexity of etiology and in methods of study and control. A similar comparison can be made between the etiology and treatment of smallpox (health

problem) and bereavement (emotional problem).

3. *The segments of population of concern for welfare problems are also comparable to those of public health.* While juvenile delinquency is largely a lower socioeconomic class problem, so are tuberculosis and the venereal diseases today. While smallpox affects all segments of the population, so do bereavement and problems that arise from early separation experiences of children, or from the diagnosis of chronic illness in parents or children.

In brief, the implied differences between public health and welfare problems are not so great as they appear.

David M. Kaplan
Associate in Social Work, School of Public Health, Harvard University

Author's reply

In response to Dr. Kaplan's three points, I would say:

1. The social work profession has much to learn from and much to contribute to the effort to maintain health and combat disease. However, certain public health prevention concepts which have been defined in respect to prevention of clearly defined disease entities can be misleading when used in respect to welfare problems.

There is a significant difference between cancer and delinquency. The definition of cancer is relatively clear. Who knows what delinquency is? As public health organizations become more interested in prevention of "emotional maladjustment" and the like, they will run into the problem with which those concerned with welfare problems are familiar; namely, the question of accountability and responsibility. One can more readily be accountable and responsible for program consequences when the target of prevention is clear.

2. Most prevention in the social welfare field involves intervention after the onset of a problem. The field has no preventive agent comparable to vaccination. Cause and effect are more obscure than in certain public health efforts. When the social work profession acts as though it had specific preventatives for welfare problems, it may fail to roll up its sleeves and work with persons who have "caught" the behavior that is supposed to be prevented. The field of public health faces the same danger as it moves into the mental health arena.

3. Surely certain diseases like certain behavior defined as "problem behavior" have higher incidence among people of the lower classes. Public health officials tend to take this into account in planning programs because where the evidence is clear and the targets of prevention sharply defined the issues cannot easily be sidestepped. When, however, a problem must be dealt with which has as many causes and manifestations as delinquency, there are dangers in approaching it as a simple entity. Thus one might define delinquency in terms of psychological maladaptation and then slip into the error of giving all clinical services for families and children the label of delinquency prevention, regardless of the likelihood of the children served ever becoming truly delinquent.

Bertram M. Beck
Associate Executive Director, National Association of Social Workers, New York

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Films on Child Life

Films listed here have been reviewed by staff members of the Children's Bureau. The listing does not constitute endorsement of a film, but indicates that its contents have merit. Charges for rental or purchase, not given because they change, may be obtained from distributors.

HOSPITAL MATERNITY CARE: FAMILY-CENTERED. 28 minutes; sound; black and white; loan.

Depicts an experiment in maternity care being conducted at St. Mary's Hospital, Evansville, Ind., to point out the needs of the individual family unit and the therapeutic roles of the father in a relaxed, home-like environment during the hospital stay; to depict how physicians and other professionals in the hospital may assist in establishing the supportive relationship needed by the family unit, and to demonstrate how regular measures regarding safety and care of both mother and infant can still be maintained in a family-centered hospital environment.

Audience: Medical, nursing, and related audiences in the health field.

Produced by: Dynamic Films, Inc.
Distributed by: Mead Johnson Laboratories, Evansville 21, Ind.

DEBBIE. 27½ minutes; sound; black and white; purchase or rent.

A documentary film about neglected and deprived children who can no longer live in their own homes and the efforts made by a child welfare agency to interpret the needs and problems of these children. Its main character is Debbie, an emotionally disturbed teenage girl who is helped and rehabilitated by such an agency.

Audience: Specialized organizations and individuals interested in the welfare of children, schools of social work and nursing; led by experienced, professional caseworkers.

Produced by: Victor Weingarten and Julius Tannenbaum.

Distributed by: Health & Welfare Materials Center, 10 East 44th Street, New York 17.

THE CHILDREN'S BUREAU—ITS FIRST FIFTY YEARS—1912–1962; filmstrip with tape recording. 1 hour; black and white; 35 mm.; loan.

Documents the historic events and activities during the 50 years of the Children's Bureau. The filmstrip was presented at the 50th anniversary celebration on April 9, 1962, with the tape recorded script narrated by Ben Grauer of the National Broadcasting Company.

Audience: Official or voluntary agencies and professional and civic groups concerned with children.

Produced by: The Children's Bureau.

Distributed (on free loan) by: Children's Bureau, Social Security Administration, Department of Health, Education, and Welfare, Washington 25, D.C.

SOME U.S. GOVERNMENT PUBLICATIONS FOR PROFESSIONAL WORKERS

Publications for which prices are quoted are for sale by the Superintendent of Documents, U.S. Government Printing Office, Washington 25, D.C. Orders should be accompanied by payment. Twenty-five percent discount on quantities of 100 or more.

NURSES AND OTHER HOSPITAL PERSONNEL: their earnings and employment conditions. Department of Labor, Women's Bureau. Pamphlet Six. Reprinted 1961 with supplement. 41 pp. 25 cents.

A reprint of a pamphlet issued in 1958 summarizing salary and employment data collected for nurses and other hospital personnel by the Department of Labor's Bureau of Labor Statistics, including a supplement presenting statistics collected in mid-1960.

COMMUNITY PLANNING AND ACTION FOR CHILDREN AND YOUTH: how to do it. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau, Region VII, 1114 Commerce Street, Dallas 2. 1962. 42 pp. Free on request from the Bureau's regional office or from the executive secretary of the Interdepartmental Committee on Children and Youth, Room 4310, 330 Independence Avenue SW., Washington 25, D.C.

The proceedings of the regional workshop held in Oklahoma City, April 9–11, 1961, in followup of the White House Conference on Children and Youth of 1960, by Federal agencies, voluntary organizations, and State committees on children and youth in New Mexico, Oklahoma, Arkansas, Texas, and Louisiana.

THE NURSE IN HOME TRAINING PROGRAMS FOR THE RETARDED CHILD. Laura Dittmann. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. 1961. 10 pp. Free on request from the Bureau.

For public health nurses providing services to families with retarded children, in special diagnostic or clinical teams or as part of a general caseload, the publication offers guidelines for helping parents teach the young child how to take care of himself and get along with others.

A DEMONSTRATION PROJECT UTILIZING CHILD DEVELOPMENT AS THE FOCUS FOR COMMUNITY INTERACTION WITH A LOCAL HEALTH DEPARTMENT. The Child Development Clinic of Children's Hospital of Los Angeles, Calif., and the California Bureau of Maternal and Child Health, State Department of Health. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. 1962. 22 pp. Single copies available from the Bureau without charge.

A report on the program and progress of a traveling clinic initiated in 1959 to service southern California counties, through local health departments, by demonstrating the multidisciplinary team approach in providing diagnostic and counseling services to the mentally retarded child and his family, planning inservice training programs for professional personnel from local health departments, schools, and social agencies, and organizing community resources for better services to the mentally retarded child and his family.

CLINICAL PROGRAMS FOR MENTALLY RETARDED CHILDREN. Rudolph P. Hormuth. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. 1962. 33 pp. Single copies available from the Bureau without charge.

Listing by States 99 special clinical facilities for mentally retarded children, this publication is the fourth such compilation made by the Children's Bureau.

Photo Credits

Frontispiece, Esther Bubley.
Page 225, Esther Bubley.

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